



Enrollment Form For:

4 Terry Drive, Suite 1, Newtown, PA 18940
Phone: (800) 482-8770 Fax: (215) 968-6301

_____ (Group Name)

Please Select One	Coverage Affected
Addition <input type="checkbox"/>	Medical Coverage <input type="checkbox"/>
Termination <input type="checkbox"/>	Dental Coverage <input type="checkbox"/>
Change <input type="checkbox"/>	Vision Coverage <input type="checkbox"/>
<input type="checkbox"/> Do not change existing coverage level.	

OptiMed Health Plans Limited Indemnity Coverage Employee Enrollment Form

Policy Number: LM-108/LM-112/LM-116/LM-117

Information (Please print in ink)

Plan Selected:	<input type="checkbox"/> Med-Choice Plus	<input type="checkbox"/> Value Care	<input type="checkbox"/> Value Care Plus	<input type="checkbox"/> Preferred Care Plus	<input type="checkbox"/> Select Care	<input type="checkbox"/> Premier Care
Medical Coverage (check one):	<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee + 1 Dependent		<input type="checkbox"/> Family	
Dental Coverage (check one):	<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee + 1 Dependent		<input type="checkbox"/> Family	
Vision Coverage (check one):	<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee + 1 Dependent		<input type="checkbox"/> Family	
Name: (Last)	(First)	(Middle Initial)	Social Security Number:		Home Telephone Number:	
Home Address: (Street)			(City)	(State)	(Zip Code)	
Status:				Occupation:	Date of Birth:	
<input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Divorced					/ /	
<input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Widowed						
Group Name:	Location:		Work Telephone Number:		Date of Hire:	
Beneficiary: (Last)			(First)	(Middle Initial)	Relationship:	Email Address:

Dependent Information (Complete only for Dependents to be covered under this plan)

Dependents Name: (First and Last)	Sex:	Date of Birth:	Social Security Number:	Full-Time Student:
Spouse:		/ /		
Child:		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

(Attach a separate sheet for additional children)

Requested Effective Date (check one):

- I request an effective date of _____ (must be the 1st of the month). I understand I cannot change this date.
- None, since I am declining coverage.

Declination of Coverage:

This section must be completed if you are declining coverage for yourself and/or your Dependents. I have been given the opportunity to apply for group insurance provided through Fidelity Security Life Insurance Company. The reason I am not applying for coverage is:

I understand the Effective Date of Coverage for myself and/or my Dependents may not be available until the next Open Enrollment Period should I desire to apply at a later date unless I am not included as a Late Entrant as defined in the Policy, or unless I apply for coverage during the Annual Open Enrollment Period.

FIDELITY SECURITY LIFE INSURANCE COMPANY Kansas City, Missouri 64111

I have reviewed this form and represent the information provided is true and complete.

I acknowledge and agree that the insurance plan presented and applied for is not a major medical policy and that the insurance benefits included in the plan are limited.

I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this application for my state of residence.

Dated at _____ on the _____ day of _____, 20 ____.

(City and State)

(Day)

(Month)

(Year)

Signature (Parent if under 18) -ENROLLER SIGNATURE-PRINT NAME

Date

M-6004/M-6005

FRAUD WARNING NOTICE

For Residents of All States (except the following):	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Tennessee	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Nebraska	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
Pennsylvania	Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.