

APPLICATION FOR HEALTH INSURANCE COVERAGE PLAN YEAR 2010

ALL employees MUST complete sections 1, 2, 3, and 8.

PLEASE PRINT -- PRESS FIRMLY

SECTION 1 Employee Information				
Last Name		First Name		M.I.
Home Address: Number, Street, and Apartment Number			Social Security #	
City			State	Zip Code
Daytime Telephone ()			Evening Telephone ()	
			Sex Male Female	
			County	
			May we call you? Yes No	
			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
			Date of marriage: ____/____/____	

SECTION 2 Mandatory Life / AD&D Insurance (if more room is needed, attach a separate sheet):		
Beneficiary's Name (Last, First, M.I.)		Social Security #
Relationship to employee		

SECTION 3 Check all of the following that apply to you:		
<input type="checkbox"/>	I choose to enroll those listed below in the Aetna Med/Vision Plan	COMPLETE SECTIONS 4 - 8
	Circle One: Platinum Gold Silver	
<input type="checkbox"/>	I choose to enroll those listed below in the MetLife Dental Plan	COMPLETE SECTIONS 4 - 8
<input type="checkbox"/>	I decline to participate in both the Aetna Medical/Vision and MetLife Dental Plan	GO TO SECTION 8
	If declining, do you have insurance through another means?	Yes No

SECTION 4 After enrollment in this plan, will you or any of your dependents have any other group insurance, including Medicare? YES NO (If yes, please complete below)		
1) Name & address of insurance company:		2) Group/Policy#
3) List of family member(s) covered by other policy (attach additional sheet if needed)		

SECTION 5 Do you wish to apply for dependent coverage? YES NO		
If "no", ___ I have no spouse/dependents ___ Spouse/dependents have other coverage		

SECTION 6 Information about YOU AND your dependents to be covered (attach sheet if needed)

Employee's Name (Last, First, M.I.)		
Date of Birth ____/____/____	Sex Male Female	Social Security #

Spouse's Name (Last, First, M.I.)		
Date of Birth ____/____/____	Sex Male Female	Social Security #

Child's Name (Last, First, M.I.)			
Date of Birth ____/____/____	Sex Male Female	Social Security #	Full Time Student? Yes No

Child's Name (Last, First, M.I.)			
Date of Birth ____/____/____	Sex Male Female	Social Security #	Full Time Student? Yes No

SECTION 7 Is employee/dependent on COBRA continuation? Yes No		
If "Yes", attach copy of original COBRA enrollment form		

SECTION 8	
By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application and the HIPAA notice, which forms a part of this application as fully as if it were contained over the employee signature. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.	
Employee Signature	Date

Disclosure Information

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

OrthoSynetics, Inc- Health Insurance Premiums-Sec 125 Tax Plan

For the current January 1 to December 31 Plan Year , All OrthoSynetics employees participate in the Sec 125 plan, which allows the employee's portion of the medical and dental insurance premium to be paid with before-tax dollars.

All participants should note the following:

- 1) Social Security benefits may be slightly reduced as a result of this election.
- 2) Annual withholding (W-2) forms will reflect the reduced taxable income.
- 3) Employees cannot change this election during the year unless there has been a significant increase in coverage cost or a change in family status (such as marriage or divorce, birth or adoption of a child, death of a spouse or child, termination or commencement of employment of a spouse, taking an unpaid leave of absence or switching from part-time to full-time status, or vice versa, by the employee or his or her spouse, or significant changes in health coverage of the employee or his or her spouse attributable to the spouse's employment). An employee must request and complete enrollment within 30 days after any significant change.
- 4) The employer may cancel this election, if necessary, to comply with the provisions of the Internal Revenue Code.
- 5) The employee's portion of the cost of the Benefit Plan paid with before-tax dollars will automatically increase or decrease, as the case may be, to reflect the changes in the cost of benefits.

Life and/or disability income coverage

I understand that I must satisfy the eligibility requirements and actively work at my employer's usual place of business on the date coverage for myself and any eligible dependents becomes effective. If I am not actively at work, I understand that coverage for myself and life coverage for my eligible dependents may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for insurance coverage, I understand that proof of good health may be required for myself and eligible dependents.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "*Special Applicant*" if:

- * I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and later apply because the other coverage terminated *involuntarily*; or
- * I did not previously elect to cover myself and/or my eligible dependent(s) and later apply for coverage because of a change in my family status resulting from marriage, birth, or adoption of a child.

I understand that to qualify as a "*Special Applicant*" I must apply for health coverage for myself and/or my eligible dependent(s) within 30 days after:

- * coverage under the prior health plan ends; or
- * I marry; or
- * I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- * I fail to qualify as a "*Special Applicant*" because I did not apply within the 30 days as specified above; or
- * I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give the insurance company or its designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation, or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement, and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

Residents of all other states- 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 is guilty of insurance fraud.

This Disclosure Information forms a part of the *Application for Insurance Coverage* as fully as if it were contained over the applicant's signature.