Altitude Holdings Services, Inc. 220020

Enrollment Form

Employer Use Only		
Date of Hire	Effective Date	Location/Department

EMPLOYEE INFORMATION

Last Name	First Name		Middle Initial
Home Address	City	State	Zip Code

Home Telephone Number ( )	Cell Number ( )	Date of Birth	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Social Security Number	Primary E-mail Address	Secondary E-mail Address:

If you wish to have your Explanation of Benefits (EOB) sent to your primary e-mail address, please check. ☐ Yes ☐ No
Note: If you choose to have it sent electronically, you **will not** receive a hard copy via regular mail.

Coverage Type:

- ☐ Employee Only (EE)
- ☐ Employee + Spouse (ESP)
- ☐ Employee + Child(ren) (ECH)
- ☐ Family (FAM)

☐ Yes ☐ No **Do you or your dependents have other insurance. If yes, and you are electing Medical coverage on yourself and/or your dependents, please complete the "Other Insurance Inquiry" and return with this form.**

DEPENDENT INFORMATION

Complete the following information for each dependent (including spouse) to be covered.

Name: Last, First, MI	Date of Birth M	D	Y	Relationship	Gender (M / F)	Social Security Number *(Required For Federal Funding)*	Check For Each Dependent
				Spouse			☐ Medical
							☐ Medical
							☐ Medical

(List additional children on a separate sheet of paper. Also provide address for children if different from employee's mailing address.)

AUTHORIZATION/SALARY REDUCTION AGREEMENT

- I understand that in order to be eligible for the coverages I have elected, I must meet any applicable actively at work requirement as defined by the insurance contracts.
- I authorize any physician, medical practitioner, hospital, clinic, or medical related facility, insurance or reinsurance company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to our Insurance Companies or their legal representative, any and all such information. I authorize the use and disclosure of my Social Security Number in the administration and provision of such benefits as may apply to me or my minor children.
- I understand Special Enrollment Rules may apply if I waive coverage for myself or my dependents when initially eligible, due to other health insurance coverage. Documentation of prior coverage may be required. By providing my e-mail address, I Authorize and Consent to the use of e-mail for communications regarding my employee benefits. I understand that my e-mail address is private and will be used solely for benefit administration purposes.

Signature_____ Date_____

EBSO USE ONLY	Rims	Rx:	Notice:	Other:

Return To: EBSO, Inc.
P.O. Box 928 Findlay, OH 45839
Fax: 414-540-9698
Email: customerservice@90degreebenefits.com

Coordination of Benefits/Other Insurance Form (Altitude Holdings Services, Inc. 220020)

If you or your dependents are enrolled in medical coverage this form must be completed and returned with your Enrollment Form. Other Insurance Information will be requested annually. Other insurance may include: coverage through a spouse's plan, required in a divorce decree or Medicare. Missing information may cause claims to be delayed.

Section I – Other Insurance Information

Other Employment Information for your Spouse:

Is your spouse employed? ☐ Yes ☐ No

Is Health Insurance available through your spouse's employer? ☐ Yes ☐ No

If yes, has your spouse declined coverage? ☐ Yes ☐ No

Other Employment Information for your Adult Dependent Child(ren) (Age 19-26):

Is your Adult Dependent Child employed? ☐ Yes ☐ No

Is Health Insurance available through your child's employer? ☐ Yes ☐ No

If yes, has your child declined coverage? ☐ Yes ☐ No

Are you, your spouse, and/or your dependents covered under any other Health Policy?

☐ Yes (Please complete sections 2 and 3) ☐ No (Please skip to section 4 and sign)

Section 2 – Other Insurance Information for Spouse

Name	Identification Number	Policyholder's Birthdate
Employer Name	Address	City, State, Zip
Other Insurance Company Name	Group Number	Family Members Covered
Insurance Company Address		Insurance Company Phone Number

Type of Policy
Medical ☐Family ☐Single Effective Date: _____

Names of family members covered by Medicare:		Medicare ID #:
Medicare Part A Eff. Date: / /	Medicare Part B Eff. Date: / /	Is Medicare eligibility due to : ☐ Kidney Failure ☐ Disability

Section 3 – Other Insurance Information for Adult Dependent (Age 19-26)

Name	Identification Number	Policyholder's Birthdate
Employer Name	Address	City, State, Zip
Other Insurance Company Name	Group Number	Family Members Covered
Insurance Company Address		Insurance Company Phone Number

Section 4 – Financial Responsibility

If you are single or divorced, have dependent children or cover stepchildren, foster children or under legal guardianship or QMCSO, please complete the following questions: Is there a court decree or QMCSO establishing financial responsibility? ☐ Yes ☐ No

If Yes, who has financial responsibility? Name: _____

Relationship: _____

Primary Residence of Dependents:

If both parties maintain insurance on the children, which parent has custody?

Please attach copy of the section of the court order, divorce decree regarding health coverage or QMCSO, if not submitted previously.

Section 5 – Signature

I certify the above information is correct and accurate to the best of my knowledge.

Employee Name (print) _____ ID# _____

Employee Signature _____ Date _____