PLANSTIN
ADMINISTRATION

EMPLOYEE ENROLLMENT FORM

COMPANY INFORMATION

Company Name: _____
Name of company, DBA or sole proprietorship

Company Contact Name: _____ _____
Last First

Company Contact Email: _____

EMPLOYEE

Full Name: _____ _____ _____ DOB: _____
Last First M/F M/D/Y

Address: _____
Street Address Apartment/Unit # City

_____ Social Security No, _____
State ZIP Code

Phone: _____ Email: _____

SPOUSE

Full Name: _____ _____ DOB: _____
M/F M/D/Y

_____
Social Security No.

DEPENDENTS

Full Name: _____ _____ DOB: _____
M/F M/D/Y

_____ _____
Relationship Social Security No.

Full Name: _____ _____ DOB: _____
M/F M/D/Y

_____ _____
Relationship Social Security No.

Full Name: _____ _____ DOB: _____
M/F M/D/Y

_____ _____
Relationship Social Security No.

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ENROLLMENT SELECTION

Preventive HSA	Preventive Co-pay MEC	Zion HealthShare	Term & Living Benefit	Accident	Dental / Vision	Tobacco User
☐	☐	☐	___	☐	☐	☐

HOUSEHOLD TYPE

EE	ES	EC	EF
☐	☐	☐	☐
Employee Only	Employee & Spouse	Employee & Child	Employee & Family

IUA *(Zion HealthShare Only)*

$1000	$2500	$5000
☐	☐	☐

ACKNOWLEDGEMENTS FOR THOSE ENROLLING IN ZION HEALTHSHARE

_____ I agree

Providing us with authorization to email and text you will allow Zion HealthShare to exchange information with you more efficiently and will benefit you as a member. At the same time, we recognize that email and text messaging are not a completely secure means of communication.

You are not required to authorize the use of email and text messages and a decision to not authorize electronic communication will not affect your health care in any way.

We have taken considerable effort to protect the personal health information of our members, and recommend that all members provide us with this authorization so that we can more efficiently communicate with them.

_____ I agree

Pre-Membership Medical Conditions Limitations

Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms for 24 months prior to the Effective Date. Needs that result from a pre-membership medical condition that existed prior to a Member's Effective Date (known or producing observable symptoms) are only shareable if the condition appears to be fully cured and 24 months have passed without any symptoms (either benign or deleterious), treatment, or medication, even if the cause of the symptoms is unknown or misdiagnosed.

_____ I agree

Waiting Period

In the first year of Membership, pre-existing conditions have a waiting period and are not sharable with the Zion HealthShare community yet. After the first year of continuous Membership, up to $25,000 can be shared with the community. After the second year of continuous Membership, up to $50,000 can be shared with the community. After the third year of continuous Membership and going forward, up to $125,000 can be shared with the community.

_____ (Please initial) **I AM WAIVING ALL BENEFITS.**

Do you have coverage through another insurance company? If so, which one? _____

MEMBERSHIP START DATE: _____ M/D/Y

SIGNATURE: _____ DATE: _____