BARTON COMMUNITY COLLEGE

FCMI FREEDOM CLAIMS MANAGEMENT, INC.

PO Box 1365 – Great Bend, KS 67530
www.freedomclaimsinc.com
866-792-9151

Group #: 911377

☐ GB/ Fort Riley ☐ Leavenworth & Out of State

EMPLOYEE ENROLLMENT/CHANGE FORM

1. REASON FOR COMPLETING THIS FORM

Check One:		**DATE TO BE EFFECTIVE:**
	New Hire	Hire Date:
	Termination	Term Date or Last Day Worked:
	Change Personal Information – Complete Changes Below	

QUALIFYING EVENTS

Check One:	Qualifying Event Date:

DATE TO BE EFFECTIVE:

	Marriage		Open Enrollment		Loss of Dependent Status		Reduction of Work Hours
	Divorce		Separation		Other Special Enrollment Event		Other:
	Birth		Adoption		Loss of Other Coverage		

2. PERSONAL INFORMATION – All Information is Required

Employee Name:		Tobacco Use		Yes		No	
SSN:		Date of Birth:		Gender:			
Address:							
City:		State:		Zip:			
Phone:		Marital Status:		Occupation:			
Email:							

3. PLAN SECTION – Medical Level II Preventive

Medical:		**I Elect/Change (Select Tier)**		**I Decline (Choose Reason)**
		Employee Only		I am covered as a dependent by another plan
		Employee + Spouse		I am covered under TriCare
		Employee + Child(ren)		Spouse/children are covered by another plan
		Family		Myself or spouse is enrolled in Medicare
				Other:

Please complete the table below for each dependent that will be covered.

List all eligible dependents you want covered under this policy (spouse, children, step-children or children of legal guardianship). Unless handicapped, to qualify for coverage a child must be under the age of 26.

Relationship (Spouse, Common Law Spouse, Child, Stepchild, Adopted Child, Legal Guardianship)	Last Name	First Name	SSN:	Birth Date	Gender M/F	Medical Check One	Dental Check One	Vision Check One
						Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No
						Yes No	Yes No	Yes No

4. OTHER COVERAGE

Do you or any other dependents have other group medical/dental coverage: YES___ NO___

Employee	***Name of insurance company***	***Medical/Dental (circle all that apply)***	***Group / Individual Medicare A/B / Medicaid (circle one)***
Spouse	***Name of insurance company***	***Medical/Dental (circle all that apply)***	***Group / Individual Medicare A/B / Medicaid (circle one)***
Dependent	***Name of insurance company***	***Medical/Dental (circle all that apply)***	***Group / Individual Medicare A/B / Medicaid (circle one)***

5. ACKNOWLEDGMENT AND AUTHORIZATION OF COVERAGE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give Freedom Claims Management, Inc. such information. A photographic copy of this authorization shall be as valid as the original and valid from the date signed for the duration of 1 year.

Employee Signature: ____Date: ____________________________

6. WAIVER OF COVERAGE

By declining coverage, I understand that I have received and understand the Special Enrollment Notice. I also understand that if I declined coverage because of other insurance and it is NOT listed in the decline reason, that I will not be eligible to enroll under this plan until open enrollment.

Employee Signature: ____Date: ____________________________