



**Markel Basic Health Insurance
Employee Enrollment Form**

MAIL FORM TO:
Pioneer Management Systems, Inc.
123 Interstate Drive
P. O. Box 9040
West Springfield, MA 01090



NEW
 CHANGE – EFF. DATE OF CHANGE _____

FAX FORM TO:
(866) 653-2542

A. SPONSOR INFORMATION (THIS SECTION TO BE COMPLETED BY THE EMPLOYER)

| | | |
|-----------------------------|-----------------------|-----------|
| NAME OF SPONSORING EMPLOYER | EMPLOYEE DATE OF HIRE | ACCOUNT # |
| SPONSOR ADDRESS | | |

B. EMPLOYEE INFORMATION

| | | | |
|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | OCCUPATION | LOCATION OF EMPLOYMENT |
| EMPLOYEE'S FULL NAME | | | GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE |
| HOME ADDRESS | | | PHONE NUMBER HOME: _____ WORK: _____ |
| Are you or any dependent proposed for insurance in full-time service of the Armed Forces? If Yes, please provide name: _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | MARITAL STATUS | |
| Are you currently performing the normal duties of your job with the Sponsoring Employer? If No, please explain: _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED | |

C. COVERAGE INFORMATION

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PERSONS TO BE COVERED <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee, Spouse, Child(ren) | PLAN SELECTION <input type="checkbox"/> Value Plan Option 1 <input type="checkbox"/> Standard Plan Option 1 <input type="checkbox"/> Enhanced Plan Option 1 <input type="checkbox"/> Value Plan Option 2 <input type="checkbox"/> Standard Plan Option 2 <input type="checkbox"/> Enhanced Plan Option 2 <input type="checkbox"/> Dental Plan |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

D. DEPENDENT INFORMATION

| IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS – if additional space is needed, please attach a separate sheet to this form | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------|---------------|-------------------|----------------------------------------------------------|
| RELATIONSHIP TO EMPLOYEE | NAME (FIRST, MI, LAST) | GENDER – F/M | DATE OF BIRTH | SOCIAL SECURITY # | FULL-TIME STUDENT? |
| SPOUSE | | <input type="checkbox"/> F <input type="checkbox"/> M | | | |
| CHILD | | <input type="checkbox"/> F <input type="checkbox"/> M | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CHILD | | <input type="checkbox"/> F <input type="checkbox"/> M | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CHILD | | <input type="checkbox"/> F <input type="checkbox"/> M | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I understand that this enrollment form is subject to acceptance by Markel Insurance Company. I understand that in order to keep my insurance in force, I must continue to be employed by the Sponsoring Employer and pay premiums when due. I authorize my employer to deduct appropriate premiums from my paycheck and forward to the insurer on my behalf. The statements contained herein are true and complete and, together with any other forms signed by me in connection with this enrollment form, form the basis for any certificate issued hereunder. I agree that any material misrepresentations shall render the insurance voidable at the instance of the insurer. All statements and descriptions are deemed to be representations and not warranties.

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. **Residents of FL, KS, LA, MD, NJ, NY, OR and VA – see notice on next page.**

Signature _____ Date _____

REFUSAL OF INSURANCE – Read & Sign Below If You Do Not Wish to Participate In This Plan

I have been given the opportunity to apply for the Group Insurance Benefits as provided under a plan of Group Insurance established by my employer. I have decided NOT to apply for this coverage. I understand that if I decide to apply for this insurance at a later date, satisfactory proof of insurability will be required at my expense.

Signature _____ Date _____



Florida Residents: 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 OF THE THIRD DEGREE.

Licensed Agent:

Florida License Number:

Agent Signature:

Kansas Residents: 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 MAY BE GUILTY OF INSURANCE FRAUD AS DETERMINED BY A COURT OF LAW, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Louisiana Residents: 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.

Maryland Residents: 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, AS DETERMINED BY A COMPETENT JURISDICTION, AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

New Jersey Residents: FRAUD WARNING: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR INSURANCE IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

New York Residents: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Oregon Residents: 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 MAY BE COMMITTING A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Virginia Residents: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.