AGE 29 CONTINUATION OF COVERAGE GROUP ENROLLMENT FORM

(Please print & complete in full to avoid any delays)

45 Broadway, Suite 300
New York, NY 10006
Tel: (212) 747-0877
www.atlantishp.com

PART 1: EMPLOYEE INFORMATION (PARENT OR GUARDIAN)

Employee First Name	Employee Last Name	
Employee Atlantis Member ID	Group Number	Group Name

PART 2: DEPENDENT INFORMATION

Dependent First Name		Dependent Last Name
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Social Security Number
Other Current Health Insurance ☐ Yes ☐ No	If Yes: Name of Insured	Name of Carrier and Insurance Policy Number

Prior Health Insurance	Effective Date	Term Date	Name of Previous Carrier and Insurance Policy Number
☐ Yes* ☐ No			

***If you answered YES, you must submit proof of coverage, "Certificate of Creditable Coverage", which is issued by your previous Carrier. If you do not provide proof of prior coverage, you will be subject to pre-existing condition exclusions.**

PART 3: TYPE OF ACTIVITY

Section 1 - Additions

Effective Date

___/___/___ ☐ **Add Dependent to Group's Make Available Election - AHP-RIDER-MA29**

___/___/___ ☐ **Add Dependent through Young Adult Election**

Election Event

☐ **During Group's Annual Open Enrollment**

☐ **Within 30 days prior to/following reaching max age**

☐ **Within 30 days after eligibilty for qualifying reasons**

Section 2 - Deletions

___/___/___ **Remove Dependent to Group's Make Available Election - AHP-RIDER-MA29**

___/___/___ **Remove Dependent through Young Adult Election**

Reason(s) _____

PART 4: SIGNATURE

I have read the information regarding this benefit option and agree to the terms and conditions of enrollment. I understand that In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 12 months from the initial enrollment date. I attest that the information I have supplied in this application is true and complete. I further understand that any person who knowingly with intent to defraud any insurance 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation.

EMPLOYEE SIGNATURE: X _____ DATE: _____

DEPENDENT SIGNATURE: X _____ DATE: _____