CONSOCIATE HEALTH

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Elected Benefits Confirmation Statement
Grask Truck Group

Please complete and return to Human Resources by 11/29/2024

Section A - Employee Information

Employee Name:	
Address:	
City, State Zip:	
Email Address:	

☐ Check here if you have changed your address. Print new address below.

_____

_____

Division:	
Plan Year:	**2025**
Alternate ID:	
Effective:	

Section B - Election Information

Member Name	Relation	DOB	Medical	Dental	Vision	Other Coverage Detail (Carrier Name, Policy Holder, Name and Date of Birth)	Is Other Coverage	
							Primary	Secondary

Section C - Other Insurance Coverage

Does any member listed above have other Medical coverage (including Medicare coverage)?

☐ NO ☐ YES -- Describe above in the "Other Coverage" section

Name of spouse's employer:_____ Address:_____

Section D - Certification and Signature

I hereby request the amount(s) and form(s) of coverage for which I am or may become eligible and I hereby authorize my employer to deduct the required contributions, if any, from my earnings. Additionally, I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to me or any of my eligible dependents to furnish Consociate and/or its designee with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish Consociate and/or its designee with information regarding benefits to which I may be entitled. I understand that the listing of my spouse and children on this form does not automatically qualify them as eligible dependents under the plan and that it is my responsibility to verify their eligibility for benefits under the terms of this plan. I understand that premiums taken out of my paycheck will be done so pre-tax unless I specify otherwise to my Human Resources Department. I agree that this authorization shall be in force until realeased by me in writing (or a new one is signed). I further understand that if I receive treatment without following the precertification procedure, I may be responsible for paying more of my medical bill. A copy of this authorization shall be as effective and valid as the original.

Date:_____ Employee's Signature:_____

Section E - Waiver of Medical Coverage

I have been given the opportunity to enroll in the Grask Truck Group Employee Health Benefit Plan and decline to participate.

Employee Signature:_____ Date:_____ Reason:_____