Nippon Life Benefits®

Nippon Life Insurance Company
of America
PO Box 25951
Shawnee Mission, KS 66225-5951

Enrollment/Change Request Open Enrollment - NJ

Group Information – to be completed by Employer

Group Name	Group Number	Class Code

A. Type of Activity – to be completed by Employer (Refer to Instructions on Page 6 before completing this form.)

	Activity – Check all that apply	Effective Date/Date of Event (mm/dd/yy)	Date of Hire/Reason for Change
1. ADD	☐ Enrollment of a new Enrollee		Date of Hire (mm/dd/yy): _____ Hours worked per week: _____
	☐ Add Spouse		Earnings: $ _____ ☐ Hour ☐ Week ☐ Month ☐ Year
	☐ Add Civil Union Partner		
	☐ Add Domestic Partner ****		
	☐ Add Dependent Child		
	☐ Add Over-age Child as a Dependent Under 31 (and complete section A4)		
	NOTE: For Spouse/Civil Union Partner/Domestic Partner/Dependent(s) to be eligible to enroll, the employee must be enrolled for the coverage.		
2. REMOVE	☐ Employee Withdrawal/Termination		
	☐ Remove Spouse		
	☐ Remove Civil Union Partner		
	☐ Remove Domestic Partner *****		
	☐ Remove Dependent Child		
	☐ Remove Over-age Child as a Dependent Under 31		
3. OTHER CHANGE	☐ Name Change		
	☐ Change Plan		
	☐ Other		

A. Type of Activity (continued)

4. COVERAGE CONTINUATION

☐ For Employee
- ☐ Total Disability*
- ☐ COBRA
  - Length of Continuation (in months):
    - ☐ 18 ☐ 29
  - Date of Loss of Coverage (mm/dd/yy): _____
  - Qualifying Event #: _____ **
  - Date of Qualifying Event (mm/dd/yy): _____
- Billing: ☐ Group ☐ Home (section B)

*Attach proof of disability

☐ For Spouse/Civil Union Partner
- Length of Continuation (in months):
  - ☐ 18 ☐ 36
- Date of Loss of Coverage (mm/dd/yy): _____
- Qualifying Event #: _____ **
- Date of Qualifying Event (mm/dd/yy): _____
- Billing: ☐ Group ☐ Home (what address?)
  - ☐ Section B OR
  - ☐ Section E

☐ For Dependent or Over-age Child
- ☐ COBRA
  - ☐ Length of Continuation (in months):
    - ☐ 18 ☐ 36
  - Date of Loss of Coverage (mm/dd/yy): _____
  - Qualifying Event #: _____ **
  - Date of Qualifying Event (mm/dd/yy): _____
- ☐ Dependent Under 31
  - Qualifying Event #: _____ **
- Billing: ☐ Group*** ☐ Home (what address?)
  - ☐ Section B OR
  - ☐ Section F

**Qualifying event #s: see list in Instructions.
***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section I.
****Applicable if employer has elected this option, attach state-stamped "Certificate of Domestic Partnership."
*****Applicable if employer has elected this option.

B. Employee Information – to be completed by the Employee

Name (last, first, MI) | Social Security Number

Home

Street/Apt: _____
Street/Apt: _____
City: _____ State: _____ ZIP Code: _____

Birthdate (mm/dd/yy): ☐ Male ☐ Female
Phone: _____

Work

Employer Name: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Phone: _____ Email: _____

Employment Date (mm/dd/yy): _____
Hours worked per week: _____
Earnings: $ _____ ☐ Hour ☐ Week ☐ Month ☐ Year

Other Health Coverage? ☐ Yes ☐ No If yes: Payer Name: _____
Policy #: _____
Medicare ID #, if any: _____

C. Plan Option – to be completed by the Employee

Basic Life	☐ Elect	☐ Waive*	Amount $ _____	
Basic AD&D	☐ Elect	☐ Waive*	Amount $ _____	
Supplemental Life	☐ Elect	☐ Waive*	Amount $ _____	
Supplemental AD&D	☐ Elect	☐ Waive*	Amount $ _____	
Dependent Life	☐ Elect	☐ Waive*	Amount $ _____	
Dependent AD&D	☐ Elect	☐ Waive*	Amount $ _____	
Dependent Supplemental Life	☐ Elect	☐ Waive*	Amount $ _____	
Long Term Disability	☐ Elect	☐ Waive*		
Short Term Disability	☐ Elect	☐ Waive*		

Medical coverage for: ☐ Myself ☐ Elect ☐ Waive* Spouse/Civil Union Partner/Domestic Partner (if applicable) ☐ Elect ☐ Waive*

☐ Children ☐ Elect ☐ Waive* _____ (number of eligible child(ren) to be covered)

Medical options (if applicable to your group policy): deductible _____ PPO network _____

If your employer offers a high option and a low option plan, please select the medical plan option which you are electing:

☐ High Plan ☐ Low Plan

Dental coverage for: ☐ Myself ☐ Elect ☐ Waive* ☐ Spouse/Civil Union Partner/Domestic Partner (if applicable) ☐ Elect ☐ Waive*

☐ Children ☐ Elect ☐ Waive* _____ (number of eligible child(ren) to be covered)

Vision coverage for: ☐ Myself ☐ Elect ☐ Waive* ☐ Spouse/Civil Union Partner/Domestic Partner (if applicable) ☐ Elect ☐ Waive*

☐ Children ☐ Elect ☐ Waive* _____ (number of eligible child(ren) to be covered)

* Reason for waiving coverage(s):

☐ Individual coverage ☐ COBRA, USERRA or state continuation ☐ Government coverage

☐ Spouse's group ☐ My Employer's HMO ☐ I am retiring from firm

☐ Other _____

Beneficiary for employee Group Term Life insurance (Example: "Doe, Mary A." not "Mrs. John Doe")

last name	first name	middle initial	relationship to you

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

D. Other Individuals Covered – to be completed by the Employee. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

1. Spouse; Civil Union Partner; or Domestic Partner (if elected by employer)	**2. Child**	**3. Child**	**4. Child**
☐ Add ☐ Remove ☐ Other ☐ Continue spouse	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L: _____ F: _____ MI: _____ Birthdate (mm/dd/yy): _____	Name (last, first, MI) L: _____ F: _____ MI: _____ Birthdate (mm/dd/yy): _____	Name (last, first, MI) L: _____ F: _____ MI: _____ Birthdate (mm/dd/yy): _____	Name (last, first, MI) L: _____ F: _____ MI: _____ Birthdate (mm/dd/yy): _____
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Social Security Number: _____	Social Security Number: _____	Social Security Number: _____	Social Security Number: _____
Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Health Coverage: ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Employed ☐ Yes ☐ No If yes, complete Section E1.	If last name is different from employee's, please explain: _____	If last name is different from employee's, please explain: _____	If last name is different from employee's, please explain: _____
Home or billing address same as Employee? ☐ Yes ☐ No If no, complete Section E2.	Living with Employee? ☐ Yes ☐ No If no, complete Section F.	Living with Employee? ☐ Yes ☐ No If no, complete Section F.	Living with Employee? ☐ Yes ☐ No If no, complete Section F.

E. Additional Spouse/Civil Union Partner or Domestic Partner (if elected by Employer) Information – to be completed by Employee. If not applicable, please mark as "NA".

1. Employer Name: _____ Employer Address: _____

City, State, ZIP Code: _____ Employer Phone: _____

2a. Street/Apt: _____

City, State, ZIP Code: _____

2b. Please explain why the address is different:

F. Additional Child Information – to be completed by Employee. Provide information below about children listed in Section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s): _____

Street/Apt: _____

City, State, ZIP Code: _____

Reason: _____

Name(s): _____

Street/Apt: _____

City, State, ZIP Code: _____

Reason: _____

G. Employee Signature – (If you have questions, concerning the benefits and services provided by or excluded under this group policy, contact a Customer Service Representative at 1-800-374-1835 before signing this form.)

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Employee signature required | Date

X

H. Over-age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election.

Employee signature required | Date

X

I. Employer Verification

The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No

Employer Representative | Date

X

Representative's Title:

Print

Instructions

Employers – you must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – you must complete sections B through H and submit the signature of each Over-age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA or Dependent Under 31 Election. Instead, select "Other" in Section A3 and attach proof of disability.

Qualifying Events

COBRA	Dependent Under 31
C1. Termination of job or reduction in hours	D1. Loss of dependent status and otherwise eligible
C2. Employee enrollment in Medicare (COBRA only)	D2. Reestablish eligibility: residency
C3. Divorce (COBRA)	D3. Reestablish eligibility: nonresident full-time student
C4. Death of employee	D4. Reestablish eligibility: change in marital status
C5. Loss of dependent child status under the plan	D5. Reestablish eligibility: change in parental status
C6. Disability (occurring subsequent to another qualifying event)	D6. Reestablish eligibility: termination of other coverage

Conditions of Enrollment – Employee Acknowledgments and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Nippon Life Insurance Company of America, or any consumer reporting agency acting on behalf of Nippon Life Insurance Company of America, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before is expires, such revocation shall not affect any action that Nippon Life Insurance Company of America has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Nippon Life Insurance Company of America will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my employer to withhold payments from my wages as contribution to the premium, as appropriate.
6. Applicable if medical coverage is an option under the group policy: I have been given a Notice to Enrollees regarding the special enrollment rights, and I understand these provisions.

Federal Regulations require an employee to receive the following notice for medical coverage.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

  Loss of eligibility includes:

  - death, divorce, legal separation, or cessation of dependent status
  - reduction in work hours or termination of employment
  - if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
  - if the other health coverage no longer offers any benefits to a class of similarly situated individuals
- **Employer contributions have terminated**
- **COBRA or state continuation has exhausted**

  Exhaustion of COBRA or state continuation includes:

  - failure of the employer or other responsible entity to remit premiums timely
  - if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
  - completion of the maximum continuation period

If you and/or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you and/or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the late enrollee provisions. An eligible dependent cannot be covered for medical benefits if the eligible employee is not enrolled as a member.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverage, your spouse and dependent child(ren) may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Special Enrollment Rights Regarding Children's Health Insurance Program (CHIP)

If you or your dependents are eligible, but not enrolled for coverage, you may enroll for coverage if:

- you or your dependent are covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility of Medicaid or CHIP coverage; or

- you or your dependent become eligible for premium assistance to purchase coverage under the group health plan.

You must enroll no later than 60 days after the date of eligibility is lost or the date you or your dependent are determined to be eligible for premium assistance. If you or your dependent do not enroll within 60 days, you will be considered a late enrollee.

Additional Information

To obtain additional information or assistance, contact:

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951
Telephone: 800-374-1835

Please keep this notice for your records.