



ASA
Agri-Services Agency

PO Box 4910
Syracuse, NY 13221-4910
1-800-654-8840

APPLICATION FOR INSURANCE

Please use Pen



New Enrollment Coverage Change Requested Effective Date: / /

Section 1 – Applicant Information

Name (First, Middle initial, Last)	Sex	Birthdate	Marital Status			Social Security #
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Legally Separated <input type="checkbox"/> Widowed			
Address (Indicate mailing address, if different)	City	State	Zip Code	County	DFA Member?	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Phone	Business Phone	Fax #	Occupation	Employer Name	Date of Hire	# Hours/Week
()	()	()			/ /	

Section 2 – Dependent Information

First Name	MI	Last Name	Social Security #	Relationship	Sex	Date of Birth	Legally Handicapped?
				Spouse	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No

For any child listed in Section 2: Child married? No Yes, name _____ Child contribute more than 50% of own support? No Yes, name _____

Section 3 - Requested Coverage

Add:	Change Due to:
<input type="checkbox"/> New Hire <input type="checkbox"/> Existing Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Death
	Event Date: / /

Section 4 - Coverage and Enrollment Selection

Coverage Selection (Choose One):		Enrollment Selection (Choose One):
PPO (Preferred Provider Organization Plan):	HSA-Compatible PPO Plan:	<input type="checkbox"/> Individual <input type="checkbox"/> 2-Person <input type="checkbox"/> Family
<input type="checkbox"/> \$ 300 deductible <input type="checkbox"/> \$ 1,000 deductible	<input type="checkbox"/> \$ 2,500 deductible	
<input type="checkbox"/> \$ 500 deductible <input type="checkbox"/> \$ 2,500 deductible	<input type="checkbox"/> \$ 5,000 deductible	1/2007

Section 5 – Payment Information

Premiums will be paid by:

- Employer
- Applicant/Self

Method of Payment:

- Direct Bill Quarterly Direct Bill Monthly
- Monthly milk check deduction **(MUST COMPLETE SECTION 6)**
- Pre-Authorized Monthly Bank Account Withdrawal
(Electronic Funds Transfer (EFT) - additional forms will be sent to you)

Section 6 – Deduction Authorization

I understand the premium as quoted includes an administrative fee per contract month, payable to Agri-Services Agency, LLC or its designee for administrative and claims service rendered to policyholders.

I hereby authorize that a deduction be made monthly from amounts due me, from any milk check, hauler check, salary or remuneration check, or pre-authorized bank withdrawal, a sum sufficient to pay or prepay the advance monthly premiums and any sums owing or becoming due as determined by the insurance provider (company) for health insurance coverage as provided for the above-named insured(s).

CO-OP NAME: _____

CO-OP MEMBERSHIP/CONTRACT # (IF APPLICABLE): _____

DFA MEMBERS: Council # _____ Payee Code _____

AUTHORIZED PERSON – SIGN HERE:

X _____ Date _____

Section 7 – Medicare Information (copy from Medicare Health Insurance Card)

1. Do you or someone to be covered have Medicare?:
 No (skip to Section 8) Yes – answer the following:
2. Name of person with Medicare: _____
3. Reason for Medicare coverage: Age (65 or over) Disability
4. Medicare Claim No. _____
5. Effective Dates for: Month Day Year
Hospital Insurance (Medicare A) / /
Medical Insurance (Medicare B) / /
6. Are you actively employed? Yes No Retirement date: ____/____/____

Section 8 – Application for Insurance

I hereby apply for coverage as indicated through Agri-Services Agency (ASA), with insurance coverage provided by Aetna. This constitutes an application for membership in Agri-Services, LLC, a wholly owned subsidiary of Dairylea Cooperative Inc. I understand coverage will be effective the first of the month following the receipt of this signed application in accordance with any employer waiting period. Required documentation must accompany the application. All information must be received by the monthly filing deadline.

I understand that I cannot change coverage or deductible options for at least one year from the effective date of my policy, except upon the occurrence of a change in my family status (for example, marriage, divorce, birth/adoption of a dependent child, death of my spouse or dependent, a change in my employment status, a change in my spouse’s employment status, a significant change in my employer-sponsored health insurance plan or my spouse’s employer-sponsored health insurance plan.)

I hereby represent that all information furnished by me on this form is true and complete to the best of my knowledge.

APPLICANT SIGNATURE – SIGN HERE:

X _____ Date _____

E-mail address: _____

Section 9 – Existing Coverage (Applies Only to New Enrollments)

Do you currently have (or have you had) medical insurance coverage?

- No - skip the remainder of Section 9
- Yes - please provide the following information concerning your existing coverage:
 - a. Name of Insurance Company: _____
 - b. Effective Date: _____
 - c. Expiration Date: _____
 - d. Identification No.: _____
 - e. Group No.: _____
 - f. Enrollment: Individual Two Person Family
 - g. Will you and/or your spouse continue to be covered under the existing or any other health insurance program? Yes No

NOTE: If you are not transferring from another health insurance plan within 63 days of cancellation, pre-existing condition benefit limitations will apply.

Broker (if applicable): _____ Broker #: _____