EXHIBIT 1

[Carrier Logo][1] Enrollment/Change Request [Carrier Name][2]

[Employer][3] Group Information - To Be Completed by [Employer]

Group Name	[Group Number	Class Code][4]

A. Type of Activity - To Be Completed by [Employer] *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
- ☐ New [Enrollee/Subscriber][5]
- Effective Date: / /
- Date of Hire: / /

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse	/ /	
☐ Add Dependent Child	/ /	
☐ Name Change	/ /	
☐ Change Plan	/ /	
☐ Other	/ /	

☐ [Add/Change Office ID Numbers: Primary / Ob/Gyn / Dentist][6]

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse*	/ /	
☐ Remove Dependent Child*	/ /	
☐ [Employee] Withdrawal/Termination	/ /	

NOTE: [Employee] must be enrolled for spouse/dependent(s) to have coverage.

* Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State - *Not all options are available. Contact [Employer] for available options.*

Coverage For: ☐ [Employee] ☐ Dependents

Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos

Date of Loss of Coverage: / /

Date of Qualifying Event: / /

[Billing: ☐ Home ☐ Group][7]

B. [Employee] Information - Complete Sections [B - H].[8]

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
[Employer] Name			Work Telephone ( )
Work Address		City, State	ZIP Code

C. Plan Option - Your selection must be offered by your [employer].

Check One:

[Indicate Plan Names/Copays/Deductibles][9]

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. [Attach proof if full-time college student.][10]

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage	[Other Rx Drug Coverage][11]	[Primary Office ID Number][12]	[Current Patient][13]	[Ob/Gyn Office ID Number][14] (If applicable)	[Current Patient]	[Dentist Office ID Number][15] (If applicable)	[Current Patient]
[Employee]			☐ ☐	/ /		Yes ☐	Yes ☐		Yes ☐		Yes ☐		Yes ☐
Spouse			☐ ☐	/ /		☐	☐		☐		☐		☐
Child			☐ ☐	/ /		☐	☐		☐		☐		☐
Child			☐ ☐	/ /		☐	☐		☐		☐		☐
Child			☐ ☐	/ /		☐	☐		☐		☐		☐

[E. Pre-Existing Conditions Statement][16]

[NOTE: This information may **ONLY** be used to determine if a condition is a pre-existing condition. You **CANNOT** be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes ☐ No ☐ 1. During the past [6][17] months, have you or any dependent covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

- ☐ a. Alcoholism or Drug Abuse
- ☐ b. Arthritis
- ☐ c. Blood Disorder
- ☐ d. Back or Neck Disorder, Injury or Pain
- ☐ e. Cancer or Tumors
- ☐ f. Diabetes
- ☐ g. Gastro or Intestinal Disorder
- ☐ h. Heart Disorder or Condition or Chest Pain
- ☐ i. High Blood Pressure
- ☐ k. Kidney or Liver Disorder
- ☐ l. Lung or Respiratory Disorder
- ☐ m. Mental or Nervous Disorder
- ☐ n. Paralysis, Stroke or Epilepsy

Yes ☐ No ☐ 2. During the past [6] months, have you or any dependent to be covered:

- ☐ ☐ a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?
- ☐ ☐ b. been advised to have treatment or surgery or testing that has not been done?
- ☐ ☐ c. been admitted to a hospital or other health care facility as an inpatient?
- ☐ ☐ d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.]

[F]. Other Insurance

Is your Spouse Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's employer.

If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

[If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.]

[G]. Dependent Information

Does any dependent listed in Section D live at a different address than the [Employee]? ☐ Yes ☐ No

If "Yes," who and what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

[H]. [Employee] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Agreement][18], contact a [Member Services][19] representative at [phone number][20] 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 on the reverse side of the [employee] copy of this application.

[Employee] Signature - *Required* X

Date / / E-Mail Address

[I]. [Employer] Verification - To Be Completed by [Employer]

[Employer] Signature - *Required* X

Title Date / /

[[Employee] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [employer]. Coverage must be verified with [Carrier Name] prior to visiting a specialist or admission to a hospital.][21]

MBNL (9-02)

NJ - HINT

[Internal Carrier Form Number][22]

Instructions

[Employer]

- Complete the **[Employer] Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section [I] - [Employer] Verification** in the lower right corner of the form.
  - [Employer] must complete this section for all new enrollments, coverage changes and terminations.
  - [Employer] must sign and date the application in order for it to be processed.

[Employee] - Complete Sections [B - H].

Section B - [Employee] Information:
Complete **all** information in order for your application to be processed.

Section C - Plan Option:
- [Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).]
- Select only an option offered by your [employer].

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- [If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).]
- If you or your dependent(s) have other Health [or Rx drug] coverage, check off the "Yes" box(es) and complete Section [F] - Other Insurance.
- [From the appropriate provider directory, locate the **[6-digit]** [23] office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.] [12, 14, 15]
- [If you are a current patient, please check the "Current Patient" box.]

[Section [E] - Pre-Existing Conditions Statement:
Complete this section for all new enrollments. **Exception**: For Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 [employees], and to late entrants.]

Section [F] - Other Insurance:
Complete this section for all new enrollments or coverage changes.

Section [G] - Dependent Information:
Complete this section for all new enrollments or coverage changes.

Section [H] - [Employee] Signature:
- Complete this section for all new enrollments, coverage changes and terminations.
- [Employee] must sign and date the application in order for it to be processed.

Section [I] - [Employer] Verification:
- [Employer] must complete this section for all new enrollments, coverage changes and terminations.
- [Employer] must sign and date the application in order for it to be processed.

Conditions of Enrollment

[Applicant] Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to [Carrier Name], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier Name] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of this authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a [Carrier Name] [plan or group policy], coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Explanation of Brackets

{Information identified in this format is offered only to explain reasons for textual changes made (usually because some element of required data for the 834 electronic enrollment form was not present on the proposed written form). This text should be deleted before publication of this form.}

1. Replace bracketed text with carrier's logo.
2. Replace bracketed text "carrier name" with carrier's full name throughout document.
3. If the carrier refers to the "Employer" using another term such as "Planholder" or "Contractholder" or some similar term, replace the term "Employer" with such other term throughout document.
4. If carrier refers to "Group Number/Class Code" using another term such as "Policy Number", "Control Number" or some similar term, replace the term "Group Number/Class Code" with such other term.
5. If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout document.
6. Omit "Add/Change Office ID Number" options if the carrier does not offer such options.
7. The continuation Billing options should be omitted if the carrier does not offer such options.
8. Renumber Sections B-H accordingly if "Section E. Pre-Existing Conditions" is being omitted.
9. Insert carrier plan options and deductibles, coinsurance or copayment options.
10. If the carrier does not want the proof of full-time student status provided with the enrollment form, omit the direction to attach proof.
11. Omit "Rx-Drug" section and corresponding question in Section F if carrier does not require.
12. Omit "Primary Office ID Number" section if the plan does not require the selection of a Primary Care Physician.
13. Omit "Current Patient" section if the carrier does not require.
14. Omit "Ob/Gyn Office ID Number" section if the plan does not require the selection of an Ob/Gyn Physician.
15. Omit "Dentist Office ID Number" section if the plan does not require the selection of a Dentist.
16. The text "and pre-existing conditions statement" should be omitted if the carrier does not elect to include the pre-existing conditions statement text as part of the standard enrollment form. Renumber succeeding sections.
17. Carrier's pre-existing condition period. For plans other than small employer plans, insert the pre-existing conditions periods that are contained in non-small employer plans. For small employer plans, the periods are 6 months and 6 months (technically 180 days).
18. If the carrier refers to the "Agreement" using another term such as "Plan," "Contract," "Policy," or some similar term, replace the term "Agreement" with such other term throughout document.
19. If the carrier refers to the "Member Services" using another term such as "Claim Office" or "Customer Service" or some similar term, replace the term "Member Services" with such other term.
20. Insert carrier's phone number.
21. Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
22. Available for carriers that use an internal number in addition to the identifying form number.
23. Identify the number in the manner appropriate to the directory.