AIARC
Association of International
Agricultural Research Centers

901 North Washington Street, Suite 706
Alexandria, VA 22314–1535, United States
Web: aiarc.org, Phone: +1.703.548.4540

IARC Insurance Plan Enrollment Form

This form is used to enroll you and your dependent(s) in the IARC Insurance Plan based on your employment classification determined by your Center. Your employment classification determines which IARC benefits that you may be eligible for. Refer to the AIARC.org website for the various employment classifications. If you have a question about your employment classification, please contact the HR Department at your Center. Please complete this form; sign and date; and return the form to your Center's HR Department for the Center Authorized Representative's signature that authorizes you to enroll in the IARC Insurance Plan. Your Center will forward this form to AIARC. Please refer to the instructions on the back of this form to assist you.

1. Participant Name: (Surname, First, Middle)	**2. Date of Birth:** (dd/mm/yyyy)
3. Permanent Address:	
Town: **Region/State:** **ZIP/Postal Code:** **Country:**	
4. Personal Email Address: **Personal Telephone Number:**	**5. Gender:** ☐ **Male** ☐ **Female**

6. Do you want to enroll in the IARC Insurance Plan? ☐ Yes ☐ No If no, you must complete the Waiver of Insurance Form.

7. If you selected "Yes" in item #6, please indicate if you have other insurance coverage? ☐ No ☐ Yes If yes, provide insurance carrier name, country, and termination date of coverage.

8. To enroll eligible dependents for insurance coverage, please complete the following information:

Dependent Name (Surname, First, Middle Initial)	**Relationship to Participant**	**Gender**	**Date of Birth** (dd/mm/yyyy)	**Other Insurance** Yes	No
	-	-		☐	☐
	-	-		☐	☐
	-	-		☐	☐
	-	-		☐	☐
	-	-		☐	☐
	-	-		☐	☐
	-	-		☐	☐

9. If you are eligible for the Life and Accidental Death and Dismemberment benefit, complete the Beneficiary Designation Form for the IARC Insurance Plan.

10. Special Remarks

11. I hereby request to participate in the IARC Insurance Plan and to receive the group insurance coverage for which I am or may become eligible. I agree to abide by the rules that govern the various types of insurance that comprise the IARC Insurance Plan as stated in the respective Plan Documents. I understand that the AIARC Board, in its sole discretion, reserves the right to change the benefits offered in the Plan at any time. My signature below affirms that all information and statements provided on this form are accurate and true. I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. Further, I have read and understand the Fraud Notice below:
Fraud Notice: Any Plan participant who intends to defraud or knowingly facilitates fraud against an insurer by submitting a request for enrollment or by filing a claim containing false or deceptive information shall be terminated from the IARC Insurance Plan, which also may result in criminal charges.

Participant Signature: _____ **Date: (dd/mm/yyyy)** _____

Note: A written signature is preferred in order to have on record. However, you can sign this form electronically, but you must also provide the signature page of your passport or government issued ID with this form. Alternatively, you can write and print your signature on a white blank piece of paper, take a photo of the written and printed signature with your smartphone, and send a copy of the photo with this form.

For Center's Use Only

12. Center Name: -	**13. Coverage Effective Date** (dd/mm/yyyy):
14. Enrollment Type: ☐ New ☐ Rehired ☐ Reinstatement	**15. Insurance Salary (US$):**
16. Signature of Center Authorized Representative:	**Date: (dd/mm/yyyy)**

For AIARC: Enrolled in ☐ Cigna ☐ CPAS	AIARC ID#	Coverage Class#	Cigna Ins #

AIARC
Association of International
Agricultural Research Centers

901 North Washington Street, Suite 706
Alexandria, VA 22314–1535, United States
Web: aiarc.org, Phone: +1.703.548.4540

IARC Insurance Plan Enrollment Form Instructions

(Form must be completed and signed by both Participant and Center Authorized Representative)

EMPLOYEE: *Please complete Items 1-10 and provide your signature in Item 11.*

Item 1: Participant Name – Provide your legal name. Your name on your insurance ID card should be the same as the name on your passport or birth certificate.

Items 2, 3 & 5: Provide accurate information for every item.

Item 4: Email Address and Telephone Number – Provide an email address and telephone number that you use frequently. AIARC will use this email address to send you your Cigna (medical insurance) online log-in information.

Item 6: If you choose *not* to enroll in the IARC Insurance Plan because you are keeping coverage with your current insurance carrier, you must complete the Waiver of Insurance Form. Contact your Center's AIARC Coordinator for this form.

Item 7: If you are planning to enroll in the IARC Insurance Plan and currently have other insurance under another plan, you must provide the following information to AIARC:

- The name of your existing insurance carrier, the country of coverage, and the end date of coverage. Please note that Cigna will be your secondary insurance provider until you terminate coverage with your existing insurance carrier.
- A copy of your Medicare A & B card if you are insured under Medicare in the United States.

Item 8: Dependent Information – To enroll your eligible dependents in the IARC Insurance Plan, *you must be a Participant* in the IARC Insurance Plan. Please make sure that you provide each dependent's **full name, relationship to you**, **gender,** and **date of birth**. The information will appear exactly the same as on the dependent(s) insurance ID cards.

- Indicate the dependent's relationship to you: Husband, Wife, Partner, Child, Divorced Spouse, and Other. (If relationship is "Other," explain in Special Remarks, Item 10.)
- Please indicate if your dependent has coverage under another insurance plan. If yes, please provide name of carrier in Item 10.
- Children upon reaching age 26 are not eligible for coverage unless they are handicapped. For more information, refer to Eligibility of Plan Benefits in the IARC Medical Plan Brochure or contact your Center's AIARC Coordinator.

Item 9: Beneficiary information – If you are eligible for the Life and Accidental Death and Dismemberment benefit, complete the Beneficiary Designation Form. If you are not sure of your eligibility for coverage, please verify with your Center. If you are eligible for coverage, indicate the person (the beneficiary) to whom the financial benefit will be paid in the event of your death.

Item 10: Special Remarks – If necessary, use this section to provide further explanation or attach a separate piece of paper if needed.

Item 11: Sign and date the form and submit the form to your Center's HR Department for the Authorized Representative's approval/signature. It is important to understand that it is the respective Plan Documents that govern the various insurance coverages that comprise the IARC Insurance Plan.

For Center's Use Only: The Center Authorized Representative must *complete items 12-16 and must provide signature to validate this form.*

Item 12: Enter Center's name.

Item 13: Effective Date of Plan Coverage – Indicate start date of participant's plan coverage. To determine the correct effective date:

- for a long-term employee, subtract 5 days from participant's employment start date or the date when he or she will report to work.
- for a short-term employee, indicate the date when the employment starts.
- for an employee on leave without pay status, indicate the date when he or she is returning to work.

Item 14: Enrollment Type: Choose an enrollment type based on the categories below:

- **New Employee –** new participant who started to work at your Center.
- **Rehired Employee –** new participant joined from another Center or participant who was previously employed at your Center.
- **Reinstatement Coverage –** participant who resumes work after a period of leave without pay.

Item 15: Annual Salary (US$) – Enter participant's annual salary.

Item 16: Center Authorized Representative: This form must be signed and dated by the Center Authorized Representative indicating his or her full name. To enroll the employee in the IARC Insurance Plan, a copy of the original signed form must be sent to and received by AIARC.

For AIARC Use only: AIARC will complete the shaded items at the top of this page. Please do not enter any information in these boxes.

- AIARC ID#, Cigna Ins #, Coverage Class#, and Plan Status # and Insurance.