

ENROLLMENT/CHANGE FORM

Employer		Plan Number		Social Security #	
Name (First, MI, Last)			Date of Birth		Sex (M/F)
Street Address		City	State	Zip	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					

EMPLOYER SECTION

<input type="checkbox"/> Open Enrollment (original eff date _____)	<input type="checkbox"/> Late Enrollment
<input type="checkbox"/> Initial Enrollment (date employed full-time _____)	<input type="checkbox"/> Change of Information/Coverage
<input type="checkbox"/> Rehire (date re-employed full-time _____)	<input type="checkbox"/> Termination/Reduction of hours (date _____)
<input type="checkbox"/> Special Enrollment - please select the reason for special enrollment and the date of the event:	
<input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Child placed for adoption <input type="checkbox"/> Loss of other coverage	
Date of event: _____	Attach supporting documentation (i.e. birth or marriage certificate, etc.)

PARTICIPANT INFORMATION

LIST THOSE DEPENDENTS TO BE COVERED

Relationship	Name (First, MI, Last)	Sex (M/F)	DOB	Medical
Spouse				
Child				
Child				
Child				
Child				
Child				

OTHER COVERAGE

Is other coverage provided for any family members? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please provide the names of individuals covered, the type of coverage provided and the company name:

BENEFICIARY INFORMATION

Name	Relationship
Address	
Contingent Beneficiary	Relationship
Address	

I declare that the above information is correct and true. I authorize payroll deduction on a pre-tax basis from my earnings for any contribution I am required to make.

Signature

Date

DECLINATION OF COVERAGE

Note: You must complete this section if you decline coverage for yourself (if single) or family coverage (if married).

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your coverage ends. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days of the event.

Signature

Date