Enrollment Form

A TO BE COMPLETED BY EMPLOYER (Complete this section for employees currently enrolled)

Employer: _____ Group # _____

B TO BE COMPLETED BY ENROLLEE ☐ New Enrollment ☐ COBRA Enrollment ☐ Change in Enrollment (see Section C) ☐ Reinstatement ☐ Transfer ☐ Rehire

Please enroll me in:

Name: _____ (Last / First / MI)

Member ID Number: ___ - ___ - _____ (Social Security Number)

Date Hired: _____ (Month/Day/Year)

Date of Birth: ___ / ___ / _____ (Month/Day/Year)

Address: _____ (Street / City/State / Zip Code)

( ) _____ (Phone)

Sex
- ☐ Male
- ☐ Female

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated

Any Dependent Children?
- ☐ Yes
- ☐ No

☐ COBRA Enrollment Loss of coverage date ___ / ___ / _____ Qualifying Events _____

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplie(_____ (Name) ___ - ___ - _____ (Social Security #) (Previous benefits received under this ss#)

C Change to Existing Enrollment (Complete all sections that apply)

☐ Name Change ☐ Add New Dependent (indicate below) ☐ Delete Dependent (indicate below) ☐ Address change listed above

Reason for change _____ Effective date of change _____

D Dependents (Complete for new enrollment or to add or delete dependents)

		Sex	Date of Birth	Marriage/Divorce Date	Social Security # (Optional)
Spouse Name Last First MI	Add ☐ Delete ☐	M F			
Childs Name Last First MI	Add ☐ Delete ☐	M F			
Childs Name Last First MI	Add ☐ Delete ☐	M F			
Childs Name Last First MI	Add ☐ Delete ☐	M F			

E Signature (Form must be signed to be processed)

I understand there may be a contribution required by me for coverage for myself or my dependents. I authorize my employer to deduct my share of the cost for coverage from my salary while the program is in force. I agree to comply with the terms of the group contract. I further understand that if I delete a dependent, an enrollment penalty may be imposed.

Enrollee Signature _____ Date _____