

Employee Benefit Enrollment Form

Group Number	Location	Employee Classification	Coverage Effective Date
			/ /

1.	Date of Birth	Mo.	Day	Yr.	Sex	<input type="checkbox"/> M	<input type="checkbox"/> F
	Mailing Address			Social Security Number			
	City	State	Zip	County:	Date Employed:		
	Name of Employer		City	Job Title:	Home Phone: ()		
2. Complete information at the right to indicate persons to be covered and coverage desired	Health Plan	<input type="checkbox"/> Myself	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Decline*	*If declining, are you enrolled in another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dental Plan	<input type="checkbox"/> Myself	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Decline		
	Other _____	<input type="checkbox"/> Myself	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Decline		
	Name						
	Spouse			Birth Date	Age	Sex	Post High School Student
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Other Insurance Information	Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer: _____				
	Is spouse enrolled in a group health plan at his/her employer (excluding this plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes--		MEDICAL PLAN	Effective Date: ___/___/___	<input type="checkbox"/> Single Coverage	<input type="checkbox"/> Family Coverage		
		DENTAL PLAN	Effective Date: ___/___/___	<input type="checkbox"/> Single Coverage	<input type="checkbox"/> Family Coverage		
4. HIPAA Information	Did you have medical insurance prior to this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	If yes, Carrier: _____ Effective Date: ___/___/___ Termination Date: ___/___/___						
	Enrollment Type: <input type="checkbox"/> New Hire <input type="checkbox"/> Special <input type="checkbox"/> Late Entrant						
	AVAILABLE UPON PURCHASE						
	Enrollment Date: ___/___/___ AVAILABLE UPON PURCHASE						
Certification of Creditable Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No							
AVAILABLE UPON PURCHASE							
Qualifying Event:							
5. Please designate your beneficiary	AVAILABLE UPON PURCHASE						
	Beneficiary			Relationship			
Your employer must Complete the section on the right.	Employee Term Life \$ _____			Employee \$ _____			
	Dependent Term Life \$ _____			Disability Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Please complete the information at right only if changed	<input type="checkbox"/> Name Change	Complete Sections: 1 and 7. Former Name was:		Last Name	First Name	Middle Initial	
	<input type="checkbox"/> Change From Single to Family Coverage	Complete All Sections. Reason & Date of Change:			Mo.	Day	Yr.
	<input type="checkbox"/> Change From Family to Single Coverage	Complete Sections 1, 2, and 7. Reason & Date of Change:			Mo.	Day	Yr.
	<input type="checkbox"/> No change in Coverage: Adding Dependents	Complete All Sections Reason & Date of Change:			Mo.	Day	Yr.
	<input type="checkbox"/> Terminating Dependent	Complete Section 1	Dependent's Name	Last Date of Coverage ___/___/___			
7. Premium Only Plan	AVAILABLE UPON PURCHASE						
	Signature _____			Date _____			
8. Authorization	AVAILABLE UPON PURCHASE						
	Signature of Applicant					Date	