

Company Name:	Group #:	Cert#:
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This Section Is To Be Completed By Employee

Last Name	First Name	M.I.	Gender	Marital Status <input type="checkbox"/> Single-S <input type="checkbox"/> Married-M <input type="checkbox"/> Divorced-D <input type="checkbox"/> Legally Separated
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SSN:	Date of Birth:	Email Address:
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Current Mailing Address:	City:	State:	Zip:
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Home Phone ()	Work Phone () (ext)
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Life Insurance Beneficiary (if applicable):	Relationship	Contingent Life Beneficiary (if applicable)	Relationship
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Address:	SSN:	Address:	SSN:
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Please Indicate the Coverage Elected for Each Dependent:

List of Eligible Dependents Full Name	Social Security # Required	Gender	Date of Birth	Relationship to Employee	Medical	Dental	Vision	Primary Care Physician (if applicable)
				SELF				

Other Health Benefit Information

Are you or any of your dependents enrolled in another health benefit plan? Yes If yes, please indicate other insurance coverage below.
 Are any of your dependent children eligible for other Employer Sponsored Coverage No Yes If yes, please indicate other insurance coverage (OIC) below.
 If other insurance coverage (OIC) information is not indicated on this enrollment form, this will imply that no other insurance coverage (OIC) is in effect and/or that no dependent children are eligible for other Employer Sponsored Coverage.

Last Name	First Name	Other Health Benefit Name, Policy Number and Phone Number:	Medicare A	Medicare B	Medical	Dental	Vision
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For the Other Insurance Coverage, please complete the following. For more than one insurance continue on the back of this form.

Other Policy Holder's name:	Other Policy Holder's Date of Birth: / /
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Type of Policy: Employer Sponsored Retiree COBRA Individual Medicaid/CHIP/Other State Program

Relationship of Policy Holder to those covered:	Effective Date of Policy: / /
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Application is made for benefits under Employer's benefit plan for which I am eligible and authorization is granted to deduct from my salary or wages any premiums required. By signing below I am indicating that, to the best of my knowledge, all information is true and accurate. I understand that if the information provided herein is determined to be inaccurate, this will be considered an intentional misrepresentation and coverage could be terminated retroactively.

<p>Accept: If you accept coverage please sign and date below. (This form is valid only if signed and dated.)</p> <p>Signature _____ Date / /</p>	<p>WAIVER OF PARTICIPATION: By my signature below, I acknowledge that coverage has been offered to me and I elect not to participate at this time.</p> <p>Signature _____ Date / /</p>
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This Section Is To Be Completed By Employer

Division Name: _____	Division #: _____	PPO _____	Date of Hire _____
Effective Date: _____	Plan: _____	Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Occupation: _____	Earnings: \$ _____	Life Insurance (if applicable) \$ _____	
<input type="checkbox"/> Initially Eligible <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Reinstatement - Date / / <input type="checkbox"/> Newborn <input type="checkbox"/> Deletion <input type="checkbox"/> Marriage <input type="checkbox"/> Name/Address			