

ENROLLMENT/CHANGE FORM

Employer		Plan Number	Soc Sec #	
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 - <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 documentation	

PARTICIPANT INFORMATION

LIST THOSE DEPENDENTS TO BE COVERED

Relationship	Name (First, MI, Last)	Sex (M/F)	DOB	Medical	Dental	Vision
Spouse				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATE OF PRIOR COVERAGE

Did you or your dependents have other coverage prior to this enrollment? Yes No

You (and your dependents) will be subject to pre-existing exclusions unless it can be established that you (and your family) have been covered by other insurance coverage for at least 12 months and have not experienced a "break in coverage" of 63 days or more. To establish this prior coverage, please provide a copy of the "Certificate of Prior Coverage" you received from your prior carrier. If you did not receive one, please request a copy and forward it to our office.

OTHER COVERAGE

Is other coverage provided for any family members? Yes No

Please provide the names of the 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 insurance 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 other 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