FOR OFFICE USE ONLY

EFFECTIVE DATE

GROUP NO.

COV. | FAMILY SIZE

ENROLLMENT FORM

COVERAGE

- ☐ 1. Single
- ☐ 2. Family
- ☐ 3. Double
- ☐ 4. Medicare
- ☐ 5. Split
- ☐ 6. Change in Participant Covered
- ☐ 7. Change Name
- ☐ 8. Change Address
- ☐ 9. Other ______

Group Coverage

☐ Medical ☐ Dental ☐ Vision ☐ RX ☐ Other ☐ STD ☐ LTD

Type of Enrollment

☐ TIMELY ☐ SPECIAL ☐ LATE ☐ REINSTATEMENT

Social Security No. ______ - ______ - ______

Name (Last, First, M.I.) ______

Street Address | Apt.# | City | State | County | Zip

Phone No. ______

IF COBRA,

please provide end date ______

If eligible for Medicare please fill out below:

EMPLOYEE		SPOUSE
☐	A & B Coverage	☐
☐	A Coverage Only	☐

MEDICARE I.D. # ______ MEDICARE I.D. # ______

INDIVIDUALS TO BE ENROLLED

	LAST NAME	FIRST	MI	DATE OF BIRTH MONTH DAY YEAR	M or F	SOCIAL SECURITY NUMBER
01 SUBSCRIBER						
02 SPOUSE						
03 DEPENDENT						
04 DEPENDENT						
05 DEPENDENT						
06 DEPENDENT						
07 DEPENDENT						

Employee/Subscriber's or Spouse's Maiden Name ______

HAVE YOU EVER BEEN ENROLLED WITH THE HEALTH PLAN BEFORE? ☐ YES ☐ NO

IF A DEPENDENT IS NOT YOUR NATURAL CHILD, PLEASE SPECIFY RELATIONSHIP:
(STEPCHILD, LEGALLY ADOPTED, LEGAL GUARDIAN, FOSTER CHILD-MUST ATTACH LEGAL DOCUMENTATION) ______

DOES SPOUSE AND ALL DEPENDENTS LISTED ABOVE RESIDE WITH THE SUBSCRIBER? ☐ YES ☐ NO
IF NO, LIST SPOUSE OR DEPENDENT(S) AND HIS/HER ADDRESS BELOW:

NAME ______ NAME ______

ADDRESS ______ ADDRESS ______

DO ANY OF THE PERSONS LISTED ABOVE HAVE ANY OTHER GROUP MEDICAL/HEALTH COVERAGE? ☐ YES ☐ NO

If yes, please provide person's name and name of other insurance carrier ______

ELECTION OF HEALTH CARE COVERAGE UNDER THE EMPLOYER FUNDED PLAN ADMINISTERED BY THE HEALTH PLAN, CLAIMS SUPERVISOR

I hereby elect coverage for myself, and for those eligible members of my family listed on this enrollment application, for the benefits offered through the Employer Funded Plan ("Plan"). Eligible family members may include my spouse, children as defined within the Employer Funded Plan Participant Handbook, and unmarried children of any age if prior to reaching age 26, they are incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon me for support and maintenance. All persons listed on this application, including myself, shall be referred to as the "family unit."

I agree for myself and other members of my family unit to be bound by the benefits, deductibles, copayments, exclusions, limitations, and other terms of the Plan, as is or as amended, as defined within the benefit provisions of the Plan. Furthermore, I agree to provide to the Plan any legal or other documentation to verify eligibility (i.e. marriage license, birth certificate, driver license, voter registration).

I understand on behalf of myself and eligible dependents, that certain information may be disclosed to other entities. (This disclosure is further explained in your Employer's Privacy Notice).

If I am required to contribute a part of the premium, I hereby agree to pay, in advance, the amount due to the Employer.

I hereby state that all information furnished by me here is true and complete to the best of my knowledge and shall be deemed representations.

INSURANCE FRAUD WARNING: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud."

______ NAME OF EMPLOYER OR GROUP | ______ EMPLOYMENT DATE | ______ SUBSCRIBER SIGNATURE | ______ DATE