ENROLLMENT/CHANGE FORM

Employer Name

☐ OPEN ENROLLMENT ☐ CHANGE
☐ NEW ENROLLMENT ☐ REINSTATE

Insured Status
☐ EMPLOYEE ☐ RETIREE
☐ DIRECTOR ☐ SURVIVOR

Date of Hire

Social Security Number

FORM MUST BE RECEIVED BY THE 24TH OF THE MONTH TO BE INCLUDED ON CURRENT INVOICE. TRANSACTIONS FOR FORMS RECEIVED AFTER THE 24TH WILL APPEAR ON A SUBSEQUENT INVOICE.

Employee Name (Last) (First) (M.I.) **(Date of Birth)**

IF MEDICARE ELIGIBLE, PLEASE CHECK
☐ PART A ☐ PART B

Address (Street) (Apt No.) (City) (State) (Zip)

TYPE OF CHANGE

☐ **Add Dependent(s)**
- ☐ Birth ☐ Marriage
- ☐ Adoption Placement
- ☐ Other _____
- ☐ Date _____

☐ **Address Change**

☐ **Name Change**

Indicate Change Above

☐ **Cancel Dependent(s)***
- ☐ Divorce/Separation ☐ Child Attained Age
- ☐ Death ☐ Medicare
- ☐ Retirement ☐ Military Service
- ☐ Other _____

***Attach coverage continuance form to insure proper COBRA Notification**

☐ **Transfer to COBRA***
- ☐ 18 months
- ☐ 29 months
- ☐ 36 months

***Attach coverage continuance form to insure proper COBRA Notification**

☐ **Retirement**

☐ **Other** _____

	EFFECTIVE DATE	SINGLE	PARENT/CHILD	HUSBAND/WIFE	FAMILY	PREVIOUS COVERAGE
HEALTH CARE _____						
DENTAL						
☐ **VISION** ***(Stand Alone Plans)***						

Please print (Specify last name if different from employee's) Last Name First Name M.I.	**DATE OF BIRTH Mo. Day Year**	**SEX**	**FULL-TIME STUDENT?**	**SOCIAL SECURITY NUMBER**	***Enter your Primary Care Physician (PCP) Name & ID Numbers Below If applicable to your plan.***		**Existing Patient?** PCP	**Existing Patient?** OB/GYN
Employee		☐ M ☐ F			PCP		☐ Yes ☐ No	☐ Yes ☐ No
Spouse		☐ M ☐ F			PCP		☐ Yes ☐ No	☐ Yes ☐ No
Dependent		☐ M ☐ F	☐ Yes ☐ No		PCP		☐ Yes ☐ No	☐ Yes ☐ No
Dependent		☐ M ☐ F	☐ Yes ☐ No		PCP		☐ Yes ☐ No	☐ Yes ☐ No
Dependent		☐ M ☐ F	☐ Yes ☐ No		PCP		☐ Yes ☐ No	☐ Yes ☐ No

SIGNATURE - I hereby enroll for benefits for which I am presently eligible. I certify that the above information is to the best of my knowledge true and complete.

EMPLOYEE'S SIGNATURE / DATE

NOTICE OF ENROLLMENT RIGHTS 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 30 days after your other coverage ends. In addition, 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 30 days after the marriage, birth, adoption or placement for adoption. You and/or your dependents (including spouse) may also have the opportunity to apply for this coverage during an open enrollment period for your group to be effective on the date of such enrollment.

I, the undersigned employee, understand my Enrollment Rights as stated. I have been offered and elect to decline coverage under the benefit plan as indicated below.

☐ Health Care ☐ Dental I decline coverage for ☐ Self ☐ Dependents

SIGNATURE _____ DATE _____

I am declining coverage for the following reason:

☐ I currently have coverage provided by _____

☐ Other _____