

GROUP BENEFIT ENROLLMENT FORM

Employer Name: _____

	LOC. #	DEPT. #	EMPLOYEE CLASS
EMPLOYEE (FIRST, MIDDLE, INITIAL, LAST)	SOCIAL SECURITY NUMBER		DATE OF BIRTH
HOME ADDRESS	APT. NUMBER	CITY	STATE ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	IN CASE OF EMERGENCY CONTACT	TELEPHONE NUMBER RELATIONSHIP
			HIRE DATE
MARITAL STATUS		MEDICARE COVERAGE	
<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED
<input type="checkbox"/> 1 - NONE	<input type="checkbox"/> 2 - PART A ONLY	<input type="checkbox"/> 3 - PART B ONLY	<input type="checkbox"/> 4 - PART A & B
			MEDICARE EFFECTIVE DATE

NEW ENROLLMENT RE-ENROLLMENT CHANGE INFORMATION

MEDICAL / RX				DENTAL				VISION			
EFFECTIVE DATE	MO.	DAY	YEAR	EFFECTIVE DATE	MO.	DAY	YEAR	EFFECTIVE DATE	MO.	DAY	YEAR
<input type="checkbox"/> SINGLE COVERAGE				<input type="checkbox"/> SINGLE COVERAGE				<input type="checkbox"/> SINGLE COVERAGE			
<input type="checkbox"/> EMPLOYEE & SPOUSE ONLY				<input type="checkbox"/> EMPLOYEE & SPOUSE ONLY				<input type="checkbox"/> EMPLOYEE & SPOUSE ONLY			
<input type="checkbox"/> FAMILY COVERAGE				<input type="checkbox"/> FAMILY COVERAGE				<input type="checkbox"/> FAMILY COVERAGE			
<input type="checkbox"/> EMPLOYEE & DEPENDENT CHILDREN ONLY				<input type="checkbox"/> EMPLOYEE & DEPENDENT CHILDREN ONLY				<input type="checkbox"/> EMPLOYEE & DEPENDENT CHILDREN ONLY			

DEPENDENTS TO BE COVERED
LIST SPOUSE AND/OR ELIGIBLE DEPENDENTS TO BE COVERED. USE SEPARATE FORM FOR ADDITIONAL INFORMATION

NAME (FIRST, MI, LAST)	DATE OF BIRTH (MO/DAY/YEAR)	SOCIAL SECURITY NUMBER	SEX	RELATIONSHIP	STUDENT DEPENDENT INFORMATION	IF STUDENT OR HANDICAPPED PLEASE INDICATE (S OR H)
EMPLOYEE						
1.						
SPOUSE						
2.						
NAME OF CHILDREN (FIRST, MI, LAST)	DATE OF BIRTH (MO/DAY/YEAR)	SOCIAL SECURITY NUMBER	SEX	RELATIONSHIP	STUDENT DEPENDENT INFORMATION	IF STUDENT OR HANDICAPPED PLEASE INDICATE (S OR H)
3.					COLLEGE ATTENDING	
4.						
5.					ADDRESS OF COLLEGE	
6.						

Have you and your dependents (If you are electing to cover your dependents) been covered under a prior employer's group health plan? Yes No

If you answered yes above, you should provide evidence of prior creditable health coverage, if any, for you and each of your dependents with your enrollment form in order to avoid being subject to a pre-existing condition exclusion. Your prior employer may have furnished this form to you.

If you or your dependents have coverage under another group health plan, please answer the following so that we may coordinate benefits with that group health plan, if appropriate. If there is no other group health plan, please indicate by answering N/A.

Name of Carrier / Phone # _____

Policy/Group Number _____ Effective Date of Coverage _____

Name(s) of Individual(s) Covered _____

Notice Of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health benefit plan 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. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee and may be subject to a waiting period before coverage can begin. 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.

Are you declining enrollment for yourself or your dependents because you or your dependents have coverage under another health benefit plan? Yes No

Signature for Refusal _____ Date _____

I hereby request insurance as indicated above under the Group Health Plan offered by my employer and authorize my employer to deduct from my earnings any required contributions. I declare that all of the statements made in this enrollment form are true and correct to the best of my knowledge and belief and that no material information has been omitted concerning the past or present state of health of me or my dependents. I understand that any misstatement or omission or dishonest or fraudulent answer may void this insurance. I understand that if my enrollment is accepted and insurance becomes effective, the insurance will be subject to all of the terms, limitations and exclusions of the Group Health Plan.