



**Enrollment Form  
Termination  
Change Form**


**EMPLOYEE INFORMATION** (Please print clearly)

Social Security No. \_\_\_\_\_ Employer \_\_\_\_\_

Name \_\_\_\_\_  
 Last First Middle Initial

Address \_\_\_\_\_  
 Street City State Zip

Mailing Address (if different) \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex M F Marital Status  Single  Married  
 Month Day Year (circle)  Separated  Divorced

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

New Employee\*  Open Enrollment\*  Change Name/Address  Termination  Add Dependent\*  
 Rehire\*  Reinstatement\*  Decline Coverage  COBRA Enrollment  Delete Dependent

**DEPENDENT INFORMATION** (List only those to be covered)

NAME (last, first, middle initial)	SEX (M/F)	BIRTHDATE	SSN	STUDENT (if over age 19) (Y/N)	OTHER COVERAGE (Y/N)
Spouse _____	_____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____	_____

Other Coverage Information:  
 Plan Name \_\_\_\_\_ Group Number \_\_\_\_\_

**COVERAGE ELECTED**

	Medical/Rx	Dental	Vision	STD
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EMPLOYER INFORMATION**

Hire Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_

Pre-Existing (Y/N) \_\_\_\_\_ (Certificate of prior coverage attached)

COBRA Only: SSN of employee if dependent enrollment only \_\_\_\_\_

Admin # **503** Group # \_\_\_\_\_ Location # \_\_\_\_\_ Plan # \_\_\_\_\_ Network \_\_\_\_\_

I hereby apply for benefits under my employer's group benefit plan(s), or decline coverage, as indicated above. I authorize payroll deductions, if required, for the cost of the coverage I have selected. I certify that the information given on this enrollment form is complete and correct, and I understand that if the information is not complete and correct, this coverage could be terminated

Signature \_\_\_\_\_ Date \_\_\_\_\_

\* May be subject to plan waiting periods or pre-existing conditions.