Enrollment and Change Form
Group #22202992

☐ Initial Enrollment ☐ Rehire ☐ Change to Existing Enrollment

Please print, using blue or black ink.

Employee Information

Social Security Number	Last Name	First Name	MI

Mailing Address	Date of Birth	Home Phone
	/ /	( )

Apt/Unit #	City	State	ZIP	Marital Status
				☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Common-law

Occupation/Title	Hours Per Week	Hire Date

Employer Information

Employer Name:	Phone:

Office Mailing Address:

Benefit Choices

☐ $1,250 Deductible ☐ $2,500 HSA Deductible ☐ $3,000 Deductible
☐ $5,000 Deductible ☐ $10,000 Deductible ☐ Outlook PPO (must also include medical underwriting form)
☐ Waive Medical Coverage

☐ Employee only ☐ Employee + 1 Dependent ☐ Employee + 2 or more Dependents

Change

☐ Add Dependents
- ☐ Newborn—date of birth ____________
- ☐ Adoption—date of placement ____________
- ☐ Marriage—date of marriage ____________
- ☐ Other ____________

☐ Name Change; former name ____________

☐ Term Dependents
- ☐ Divorce or Legal Separation—Date____________
- ☐ Child no longer a student as of ____________
- ☐ Dependent child married on ____________
- ☐ Other ____________

☐ Other change not listed here ____________

Enrollment Information
Please provide the requested information for only those members affected by the requested change

Mbr	Name	Date of Birth (MM/DD/YY)	Relation to Employee	Sex	Social Security Number (Required)	If over age 19 Student?	Disabled?
EE			Self				
SP							
CH							
CH							
CH							
CH							

If spouse's last name is different than employee's last name, please check one of following: ☐ wife uses maiden name ☐ common-law marriage
Please attach declaration for common-law spouse.

Do you or any of your dependents listed above currently have other coverage, including Medicare? ☐ No ☐ Yes; please provide the following information:

Member Name:	Employer Name:

Insurance Company Name, Address & Phone Number	Policy Number	Medicare A, B or both

Have you or any of your dependents listed above had any other group medical plan within the last 18 months? ☐ No ☐ Yes; please provide the name of the carrier, effective dates and certificates of coverage. NOTE: If there is not proof of satisfactory prior creditable coverage, pre-existing limitations as defined in the policy booklet may apply.

I certify that, to the best of my knowledge, the information shown on this document is correct.

____________ Employee Signature ______ Date ____________ Employer Signature ______ Date

For Employer and CNIC Use Only

Date of Hire	Effective Date of Coverage	Location	Plan/Cov/Class	Pre-x End Date	Date Entered	Packet Sent