



Name of Employer _____

Please print, using blue or black ink.

Employee Information

Social Security Number		Last Name		First Name		MI
Mailing Address				Home Phone		Work Phone
Apt/Unit #	City	State	ZIP	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Common-law

Benefit Choices

Before completing this section, please ask your Plan Administrator which of the benefits are offered by your employer.

Medical	Dental	Vision
<input type="checkbox"/> PPO1 <input type="checkbox"/> PPO2 <input type="checkbox"/> PPO3 <input type="checkbox"/> EPO1 <input type="checkbox"/> EPO2 <input type="checkbox"/> Other _____ <input type="checkbox"/> No Medical Coverage	<input type="checkbox"/> EE only <input type="checkbox"/> EE+Spouse <input type="checkbox"/> EE+Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> PPO1 <input type="checkbox"/> PPO2 <input type="checkbox"/> PPO3 <input type="checkbox"/> EPO1 <input type="checkbox"/> EPO2 <input type="checkbox"/> Other _____ <input type="checkbox"/> No Dental Coverage	<input type="checkbox"/> EE only <input type="checkbox"/> EE+Spouse <input type="checkbox"/> EE+Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> PPO1 <input type="checkbox"/> PPO2 <input type="checkbox"/> PPO3 <input type="checkbox"/> EPO1 <input type="checkbox"/> EPO2 <input type="checkbox"/> Other _____ <input type="checkbox"/> No Vision Coverage

Other Benefits

<input type="checkbox"/> Employee Life	<input type="checkbox"/> Spouse Life	<input type="checkbox"/> Dependent Life	<input type="checkbox"/> LTD
<input type="checkbox"/> Employee AD&D	<input type="checkbox"/> Spouse AD&D		<input type="checkbox"/> STD

Flexible Spending Accounts:
 Medical \$_____/year Dependent Care \$_____/year

Salary (if any benefit is based on salary) \$ _____	Job Title (if any benefit based on title) _____
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Enrollment Information

Please provide the requested information for yourself and all of your dependents who will be covered by any of the benefits chosen above.

Mbr	Last Name	First Name	Relation to Employee	Sex	Date of Birth (MM/DD/YY)	Social security Number	If over age 19	
							Student?	Disabled?
EE			Self	<input type="checkbox"/> M <input type="checkbox"/> F				
SP				<input type="checkbox"/> M <input type="checkbox"/> F				
CH				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CH				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CH				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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 or domestic partner.

Do you or any of your dependents 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 had any other group medical plan within the last 18months? 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 form is correct.

Employee Signature _____ Date _____

For Employer and CNIC Use Only				
Date of Hire	Effective Date	Group/Location	Cov/Class/Plan	Life Volume EE/SP/Dep