MEDICAL AND DENTAL ENROLLMENT / CHANGE FORM

Name of Employer	Group#	Account#	Dept./Location Code	Date of Hire	Effective Date of Coverage
				/ /	/ /

ENROLLMENT	STATUS CHANGE / CHANGE OF COVERAGE
☐ NEW ENROLLMENT ☐ WAIVER	☐ NAME CHANGE ☐ ADDITION OF DEPENDENTS ☐ TERMINATION OF DEPENDENTS ☐ COVERAGE CHANGE
☐ REENROLLMENT ☐ OPEN ENROLLMENT	☐ TERMINATION OF EMPLOYEE & DEPENDENT COVERAGE ☐ OTHER ______________________

Employee Information

SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER	EMPLOYEE ID#	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYEE NAME (FIRST, MI, LAST)	EMPLOYEE ADDRESS STREET	CITY	STATE	ZIP	EMPLOYMENT STATUS ☐ ACTIVE FULL-TIME ☐ COBRA

MEDICAL PLAN OPTION ☐ **PPO PLAN** ☐ **EPO PLAN** ☐ **HDHP PLAN**

LEVEL OF COVERAGE

MEDICAL: ☐ **EMPLOYEE ONLY** ☐ **EE + SPOUSE** ☐ **EE + 1 CHILD(REN)** ☐ **EE + SPOUSE + 1 CHILD (EPO/PPO only)** ☐ **FAMILY** ☐ **DECLINE**

DENTAL: ☐ **EMPLOYEE ONLY** ☐ **EE + SPOUSE** ☐ **EE + CHILD(REN)** ☐**FAMILY** ☐ **DECLINE**

RELATION -SHIP	NAME (LAST, FIRST, MI)	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	MEDICAL INSURANCE SELECTION	SPECIAL STATUS
SELF					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE
					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE
					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE
					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE
					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE
					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE
					☐ MED/DEN ☐ MED ONLY ☐ DEN ONLY	☐DISABLED ☐MEDICARE

OTHER INSURANCE COVERAGE / MEDICARE Are you, your spouse or dependent children eligible and/or enrolled in another medical plan(s)? ☐ Yes ☐ No If yes, indicate other health plan.					
NAME OF INSURED WITH OTHER COVERAGE (LAST, FIRST, MI)	SOC SEC NO	DATE OF BIRTH	OTHER INSURANCE CARRIER / PLAN ADDRESS	EFFECTIVE DATE	EXPIRATION DATE
EMPLOYER NAME	WHO IS COVERED? CHECK ALL THAT APPLY ☐ INSURED ☐ SPOUSE ☐ CHILDREN		COVERAGE INCLUDES: HEALTH ☐ YES ☐ NO DENTAL ☐ YES ☐ NO		
MEDICARE EMPLOYEE: ☐ MEDICARE A ☐ MEDICARE B			MEDICARE DEPENDENT: ☐ MEDICARE A ☐ MEDICARE B		

COVERAGE / CHANGE OF COVERAGE / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request coverage and authorize deductions, if any, from my pay for my portion of the cost of the benefits to which I may be entitled under this plan. I understand that it is my responsibility to report to the plan any changes in eligibility of my dependents or myself. I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about my health status and health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original.

Employee Signature: ______________________________ **Date:** ____________________

COVERAGE WAIVER (FOR CONTRIBUTORY COVERAGES ONLY)

The Benefits have been explained to me thoroughly. I DO NOT wish to enroll and understand that I will not be entitled to any benefits provided by this plan.

Employee Signature:______________________________

Date:____________________