Employee Enrollment / Change Form

Please write legibly, complete all applicable sections, and sign where indicated.

EMPLOYER INFORMATION

Group Name

Check appropriate box(es) and provide effective date

☐ **Medical** ☐ **Dental** ☐ **Vision** **Effective Date** ________________________________

☐ **New Group** ☐ **Family Addition** ☐ **New Hire** ☐ **Other-Specify**:____________________________

☐ **COBRA Enrollment/Qualifying Date** __________

EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial
Home Address	City/State	Zip Code
Home Phone	Work Phone	Hire Date
Social Security Number	Date of Birth	Sex

Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced/Separated**

Are you or your dependants covered by another plan ☐**Yes** ☐**No** **Medical** ☐ **Dental** ☐ **Vision** ☐
Carrier's Name:

SPOUSE

Last Name	First Name	Sex	Social Security	Date of Birth

CHILDREN

Last Name	First Name	Sex	Social Security	Date of Birth
1.				
2.				
3.				
4.				
5.				

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I provide this information as part of my employer's application for coverage for myself and my eligible dependants listed above. To the extent that I am responsible for the payment of plan costs, I authorize appropriate deductions from my earnings. I authorize any "provider of care", insurer, third party administrator, or health plan to release information regarding me, my spouse and/or my children as necessary and for the purpose of determining claims for benefits, quality assurance, and peer review. This authorization will remain in effect for the term of coverage under my employer's plan. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to a copy of this authorization.

Employee Signature:_____________________________________ **Date:**_____________________

Mail completed form to Administrative Solutions Inc., PO Box 5809 Fresno CA 93755-5809 or fax to 559-256-1321