



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				
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> HRA <input type="checkbox"/> MEC Effective Date: _____				
<input type="checkbox"/> New Group <input type="checkbox"/> Family Addition <input type="checkbox"/> New Hire <input type="checkbox"/> Other-Specify: _____				
<input type="checkbox"/> Termination/Date _____ <input type="checkbox"/> COBRA Enrollment/Qualifying Date _____				
EMPLOYEE INFORMATION				
Last Name	First Name	Middle Initial		
Home Address	City/State	Zip Code		
Email Address (required)	Phone Number	Hire Date		
Social Security Number	Date of Birth	Sex		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated				
Are you or your dependents covered by another plan <input type="checkbox"/> Yes <input type="checkbox"/> No Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>				
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 dependents 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: _____				