



ENROLLMENT/CHANGE FORM

FOR EMPLOYER USE ONLY

Group No. _____

Contract Type _____

Effective Date _____

Check One

- New Enrollment New Social Security Number/
Employee ID Number
- Name Change
- Facility Change* Address Change
- COBRA Add Dependent
- Remove Dependent

Indicate effective date of change:
*(Does not pertain to facility change)

____ (Month) ____ (Day) ____ (Year)

COBRA Enrollment Only

Please indicate qualifying event:

- Termination Widowed Surviving Dependent
- Divorce Overage Dependent

Indicate qualifying date:

____ (Month) ____ (Day) ____ (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ (Last) _____ (First) _____ (M.I.)

Mailing Address: _____ (Street Address)
 _____ (City) _____ (State) _____ (Zip Code)

Date of Birth: _____ (Month) _____ (Day) _____ (Year) Male Home _____
 Female Phone #: (____) _____ - _____

Name of Employer/Group: _____

Location: _____

Soc. Security #: _____ - _____ - _____ Employee Identification #: _____

Contract Facility Name: _____ Contract Facility #: _____

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.) Note: You may choose up to three separate offices for yourself and all dependent enrollees.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Relationship Code*	Dependent Name	Male/ Female	Date of Birth	Contract Facility Name	Contract Facility #:
		(Check One) M F	(Month) (Day) (Year)		
		<input type="checkbox"/> <input type="checkbox"/>			
		<input type="checkbox"/> <input type="checkbox"/>			
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		<input type="checkbox"/> <input type="checkbox"/>			

*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows:

Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC

Signature of Primary Enrollee _____ Date _____