



ENROLLMENT/CHANGE FORM

FOR EMPLOYER USE ONLY

Group No. _____
 Contract Type _____
 Effective Date _____

Check One

- New Enrollment
- Name Change
- Facility Change*
- COBRA
- New Social Security Number/
Employee ID Number
- Address Change
- 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
- Divorce
- Widowed
- Overage Dependent
- Surviving 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)

E-mail Address: _____

Date of Birth: _____
(Month) (Day) (Year) Male Female Home 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"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<input type="checkbox"/> <input type="checkbox"/>	____ ____ ____	_____	_____
____	_____	<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 _____