

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
 - Surviving Dependent
 - 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)
E-mail Address: _____

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

Name of Employer/Group: _____ Male Home
Location: _____ Female Phone #: (_____) _____
Soc. Security #: _____ Employee Identification #: _____ Contract
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	Date of Birth (Month) (Day) (Year)	Male/Female (Check One) M F	Contract Facility Name	Contract Facility #

*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 _____