Employee Benefits Enrollment

ENROLLEE

SOCIAL SECURITY NO.	ENROLLEE LAST NAME	FIRST NAME	INIT.
| | |-| | |-| | | |			

STREET ADDRESS

CITY	STATE	ZIP	BIRTHDATE	SEX (M/F)
			/ /	

MARITAL STATUS	DATE OF MARRIAGE	HOME PHONE	WORK PHONE
☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ LEGALLY SEPARATED	/ /	( )	( )

ARE YOU PRESENTLY EMPLOYED ELSEWHERE? ☐ YES ☐ NO

ARE YOU RETIRED? ☐ YES ☐ NO

IF YES TO EITHER OF THE TWO PRECEDING QUESTIONS PLEASE COMPLETE THE FOLLOWING ▼

NAME OF OTHER OR PREVIOUS EMPLOYER	DO YOU HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE THRU YOUR OTHER OR PREVIOUS EMPLOYER? ☐ YES ☐ NO **IF YES, COMPLETE THE FOLLOWING**

TYPE OF BENEFITS	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE
PLEASE CHECK (√) HEALTH ☐		/ /	/ /	INDIVIDUAL ☐ FAMILY ☐
DENTAL ☐		/ /	/ /	INDIVIDUAL ☐ FAMILY ☐
OTHER ☐ TYPE _____		/ /	/ /	INDIVIDUAL ☐ FAMILY ☐

AGENCY	DEPT.	DIV.

EMPLOYMENT DATE	TERMINATION DATE	RETIREMENT DATE
/ /	/ /	/ /

SALARY CODE	UNION CODE	UNION CO. EFF. DATE
		/ /

POSITION JOB TITLE	JOB NO.

ENROLLEE CLOCK NO.	ANNUAL SALARY

EMPLOYMENT STATUS CHECK (√) ONE	DATE STATUS EFF.	CODE
	/ /	

☐ ACTIVE/FULL TIME ☐ LEAVE OF ABSENCE ☐ TERMINATION
☐ ACTIVE/PART TIME ☐ DISABLED ☐ COBRA
☐ ACTIVE/TEFRA ☐ DECEASED ☐ MISCELLANEOUS
☐ RETIRED ☐ SURVIVOR

BENEFITS

TYPE	OPTION	YES/NO	SINGLE/FAMILY	CODE	EFFECTIVE DATE	CODE	CANCELLATION DATE

INSTRUCTIONS

ENROLLEE - Complete all unshaded areas and sign the form. If family coverage applies, please make sure both sides of the form are completed.

CHANGES -
Employee should make changes by entering corrected data below the preprinted data and sign the form. It is not necessary to complete the entire form, only those unshaded areas where current information is to be changed.

I certify that all the information is correct.

Date _____ Employee Signature _____

Date _____ Employer Signature _____

LIST ALL ELIGIBLE DEPENDENTS ON OTHER SIDE OF FORM

SPOUSE

01	LAST NAME (IF DIFFERENT)	FIRST NAME	INIT.

BIRTHDATE	SEX (M/F)	EMPLOYED	DISABLED	DATE DISABLED	MEDICARE	SPOUSE SOC. SEC. NO.
/ /		☐ YES ☐ NO	☐ YES ☐ NO	/ /	YES NO	| | |–| | |–| | | |

NAME OF SPOUSE'S EMPLOYER	DOES YOUR SPOUSE HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE? **IF YES, COMPLETE THE FOLLOWING** ☐ YES ☐ NO

TYPE OF BENEFITS PLEASE CHECK (✓)	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE
HEALTH ☐		/ /	/ /	INDIVIDUAL ☐ FAMILY ☐
	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE
DENTAL ☐		/ /	/ /	INDIVIDUAL ☐ FAMILY ☐
	NAME OF CARRIER/ADMINISTRATOR	EFFECTIVE DATE	CANCELLATION DATE	COVERAGE
OTHER ☐ TYPE ______		/ /	/ /	INDIVIDUAL ☐ FAMILY ☐

If a dependent is age 19 or over, a student certification must be completed.

OTHER DEPENDENTS

LAST NAME (IF DIFFERENT)	FIRST NAME	INIT.	BIRTHDATE	SEX M/F	RELATIONSHIP TO ENROLLEE	EMPLOYED	COLLEGE STUDENT
			/ /			☐ YES ☐ NO	☐ YES ☐ NO
DISABLED	**DATE DISABLED**	**MEDICARE**	**DEPENDENT SOC. SEC. NO.**		**NAME OF EMPLOYER/COLLEGE**		**EXPECTED GRADUATION DATE**
☐ YES ☐ NO	/ /	☐ YES ☐ NO	| | |–| | |–| | | |				/ /
LAST NAME (IF DIFFERENT)	**FIRST NAME**	**INIT.**	**BIRTHDATE**	**SEX M/F**	**RELATIONSHIP TO ENROLLEE**	**EMPLOYED**	**COLLEGE STUDENT**
			/ /			☐ YES ☐ NO	☐ YES ☐ NO
DISABLED	**DATE DISABLED**	**MEDICARE**	**DEPENDENT SOC. SEC. NO.**		**NAME OF EMPLOYER/COLLEGE**		**EXPECTED GRADUATION DATE**
☐ YES ☐ NO	/ /	☐ YES ☐ NO	| | |–| | |–| | | |				/ /
LAST NAME (IF DIFFERENT)	**FIRST NAME**	**INIT.**	**BIRTHDATE**	**SEX M/F**	**RELATIONSHIP TO ENROLLEE**	**EMPLOYED**	**COLLEGE STUDENT**
			/ /			☐ YES ☐ NO	☐ YES ☐ NO
DISABLED	**DATE DISABLED**	**MEDICARE**	**DEPENDENT SOC. SEC. NO.**		**NAME OF EMPLOYER/COLLEGE**		**EXPECTED GRADUATION DATE**
☐ YES ☐ NO	/ /	☐ YES ☐ NO	| | |–| | |–| | | |				/ /
LAST NAME (IF DIFFERENT)	**FIRST NAME**	**INIT.**	**BIRTHDATE**	**SEX M/F**	**RELATIONSHIP TO ENROLLEE**	**EMPLOYED**	**COLLEGE STUDENT**
			/ /			☐ YES ☐ NO	☐ YES ☐ NO
DISABLED	**DATE DISABLED**	**MEDICARE**	**DEPENDENT SOC. SEC. NO.**		**NAME OF EMPLOYER/COLLEGE**		**EXPECTED GRADUATION DATE**
☐ YES ☐ NO	/ /	☐ YES ☐ NO	| | |–| | |–| | | |				/ /

If more space is needed to list dependents, please use another form. Be sure to enter your social security number on any additional forms.