



GROUP ENROLLMENT CARD

(800) 350-0148

EMPLOYER	GROUP NUMBER	EFFECTIVE DATE
----------	--------------	----------------

ENROLLMENT (CHECK ONE) <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> WAIVE		DIV/DEPT/CLASS/LOC		MEDICAL PLAN OPTION (CHECK ONE) <input type="checkbox"/> EPO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP (HSA)			
EMPLOYEE LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH		SOCIAL SECURITY NO.
STREET ADDRESS						TELEPHONE	
CITY					STATE	ZIP CODE	
DATE OF HIRE		<input type="checkbox"/> SALARIED <input type="checkbox"/> ACTIVE <input type="checkbox"/> HOURLY <input type="checkbox"/> RETIRED		OCCUPATION		LIFE CLASS / AMOUNT	
MARITAL STATUS (CHECK ONE) <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED						GENDER (CHECK ONE) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DO YOU HAVE ANY OTHER MEDICAL / DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO						POLICY NO.	
NAME OF CARRIER:							
I ELECT MEDICAL COVERAGE FOR: <input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(ren) <input type="checkbox"/> SELF & FAMILY							
I ELECT DENTAL COVERAGE FOR: <input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(ren) <input type="checkbox"/> SELF & FAMILY							
REASON FOR DECLINING COVERAGE:							
I DECLINE MEDICAL COVERAGE FOR: <input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(ren) <input type="checkbox"/> SELF & FAMILY							
I DECLINE DENTAL COVERAGE FOR: <input type="checkbox"/> SELF <input type="checkbox"/> SELF & SPOUSE <input type="checkbox"/> SELF & CHILD(ren) <input type="checkbox"/> SELF & FAMILY							
REASON FOR DECLINING COVERAGE:							
IF YOU ELECTED TO COVER YOUR DEPENDENTS, PLEASE COMPLETE THIS SECTION – EFFECTIVE DATE:							
NAME	DOB	SEX (M/F)	RELATIONSHIP	SOC. SEC. NO.	MEDICARE (Y/N)	OTHER INS. (Y/N)	
BENEFICIARY (life insurance)						RELATIONSHIP	
COMMENTS							

IF THE GROUP PLAN PROVIDES THAT ANY CONTRIBUTION BE MADE BY ME, I AUTHORIZE MY EMPLOYER TO DEDUCT THEM FROM MY PAY.

EMPLOYEE SIGNATURE	DATE