



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)

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 (Check One) M F	Date of Birth (Month) (Day) (Year)	Contract Facility Name	Contract Facility #:
____	_____	<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"/>	____ ____ ____	_____	_____
____	_____	<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 _____