BENEFITS ENROLLMENT APPLICATION

EMPLOYER USE ONLY

Group Name

Group No. | Sub Group #

Effective Date Requested ______/______/______

SECTION 1

Your Last Name | First | M.I.

Address

City | State | Zip Code

Your Social Security No. ____________________

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Date of Marriage ______/______/______ Date of Divorce ______/______/______

Phone No.: (________)________________

Employment Status: ❑ Full-time ❑ Part-time ❑ Active ❑ Retired ❑ COBRA

Date of Employment _____/_____/_____ Date of Retirement _____/_____/______

SECTION 2

❑ New Enrollment/Reinstatement (complete Section 4)

❑ Change Coverage from ____________ to ____________ (check new coverage)

❑ Add Dep. to Age 29: Parent's SSN: ____________________

❑ Cancel Coverage: (check those that apply)

❑ Add or Delete Dependent: (complete Section 4)

❑ Change Enrollee's Information:

REASON:______________________________

Type	Plan Code(s)	Individual	2 Person	Family	Complement to Medicare
Indemnity		❑	❑	❑	❑
PPO		❑	❑	❑	❑
POS		❑	❑	❑	❑
HMO		❑	❑	❑	❑
Dental		❑	❑	❑	❑
Vision		❑	❑	❑	❑
Drug		❑	❑	❑	❑

SECTION 3

OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family? ❑ No ❑ Yes

If Yes; Policyholder Name | Relationship ❑ Self ❑ Spouse ❑ Child

Social Security Number | Birthdate _____/______/_____

Insurance Co. Name | Policy #

Address

Plan Type ❑ Self Only ❑ Self and Family **Coverage Type** ❑ Health ❑ Drug ❑ Dental ❑ Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of Medicare card required

FOR CDPHP EPO AND EMPIRE PPO ENROLLMENT ONLY

ADD	DELETE	Relationship	DEPENDENT NAME Last / First / M.I	Birthdate	Full-Time Student	Dependent to age 26	Social Security#	Medicare A & B	Disabled?	Primary Physician - OB/GYN	Existing Patient ✔
❑	❑	**Self** ❑ M ❑ F		___/___/___			_____-____-_______	____/____/____ ____/____/____	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Husband ❑ Wife		___/___/___			_____-____-_______	____/____/____ ____/____/____	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Son ❑ Daughter		___/___/___	❑ Yes ❑ No	❑ Yes ❑ No	_____-____-_______	____/____/____ ____/____/____	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Son ❑ Daughter		___/___/___	❑ Yes ❑ No	❑ Yes ❑ No	_____-____-_______	____/____/____ ____/____/____	❑ Yes ❑ No	PCP / OB/GYN	
❑	❑	❑ Son ❑ Daughter		___/___/___	❑ Yes ❑ No	❑ Yes ❑ No	_____-____-_______	____/____/____ ____/____/____	❑ Yes ❑ No	PCP / OB/GYN	

SECT. 5

Do your dependents reside in your home? ❑ Yes ❑ No If No give address:

List names	School Name and Address	Expected Graduation:

AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Applicant's Signature ______________________________ Date ____________________

Employer's Signature ______________________________

Date ______/ ______/ ______

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