BENEFITS ENROLLMENT APPLICATION

EMPLOYER USE ONLY

Group Name

Group No. | Sub Group #

Effective Date Requested ____/____/____

SECTION 1

Your Last Name | First | M.I.

Your Social Security No. ____________

Address

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Marriage ____/____/____ Date of Divorce ____/____/____

City | State | Zip Code

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
EPO CDPHP		☐	☐	☐	☐
PPO Highmark		☐	☐	☐	☐
Life		☐	☐	☐	☐
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 ____/____/____