

Company's Name: _____

 New Employee
 Change (complete name, SSN and any item changing)
 COBRA effective date: _____

Plan No.: _____ **Department:** _____

Section 1 - Employee Information			Social Security No.		Sex	Date of Birth	
Last Name	First Name	Middle Initial					
Home Address			City	State	Zip Code	Telephone Number ()	
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Employment Date	Effective Date	Termination Date	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation or job title	Annual Earnings	Beneficiary's full name			Beneficiary Relationship		
Section 2 - Insurance Benefits			Medical	Life	Dental	Life Amount	
Health Coverage for:			Employee	Spouse	Children	\$	
<input type="checkbox"/> Employee <input type="checkbox"/> EE & Spouse <input type="checkbox"/> Life Only	<input type="checkbox"/> EE & Children <input type="checkbox"/> None		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Section 3 - Change In or Addition of Dependents Coverage						Other - Give reason and date:	
<input type="checkbox"/> Add Dependent Coverage		<input type="checkbox"/> Delete Dependent Coverage Date: _____		_____			
<input type="checkbox"/> Marriage Date: _____		<input type="checkbox"/> Birth of first/subsequent child Date: _____		_____			
<input type="checkbox"/> Divorce Date: _____		<input type="checkbox"/> Last dependent child reached age limit Date: _____		_____			
Section 4 - Persons Proposed for Coverage							
	First Name	Middle Initial	Last Name	Social Security Number	Sex	Date of Birth	Full-time student?
Employee							
Spouse							
Child							
Child							
Child							
Child							
Child							

I understand that if the coverage applied for becomes effective, it will be subject to all of the terms of the Group Plan. I am employed by the employer shown and, at present, am working full-time at least 30 hours per week for this employer at the regular place of business. If contributions are required, until further notice, I authorize my employer to make deductions from my earnings for the cost of participating in my employer's benefit plan. I understand that coverage is not guaranteed and will not become effective unless approved by The Company.

Date: _____ **Employee's Signature:** _____

TO DECLINE HEALTH COVERAGE - complete below:

After consideration, I decline to enroll for the major medical coverage (including dental insurance if provided by the plan) offer by my employer.

 I waive coverage for: Myself My spouse My children

 I am covered as a dependent under my spouse's group health coverage.

 Name of spouse's employer / insurance carrier: _____

 I am covered under CHAMPUS / CHAMPVA or as a dependent of military service personnel. Serial No.: _____

 My spouse and/or children are covered under another group plan - name of carrier _____

I understand that if I apply for coverage in the future, I may be required to furnish evidence of insurability for myself and/or my dependents at my own expense. Additionally, if dental is on the plan, certain dental benefits may be delayed subject to a waiting period.

Date: _____ **Employee's Signature:** _____