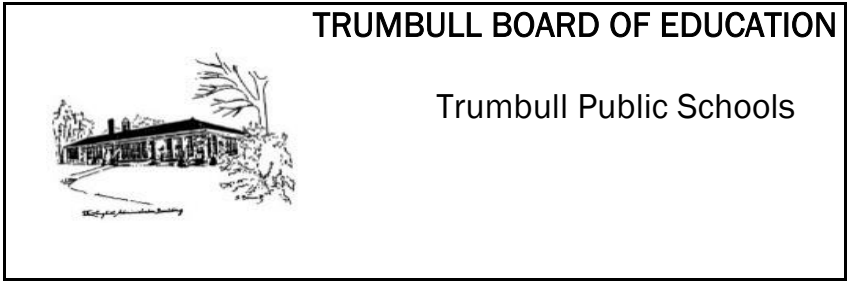


Health Insurance Enrollment / Change Form

New Enrollee	<input type="checkbox"/>
Name Change	<input type="checkbox"/>
Address Change	<input type="checkbox"/>
Add Coverage	<input type="checkbox"/>
Term Coverage	<input type="checkbox"/>
Add Dependent	<input type="checkbox"/>
Term Dependent	<input type="checkbox"/>



Employee Name (Last, First)

Street Address

City, State & Zip

Phone No. (Home) **

Phone No. (Cell) **

EFFECTIVE DATE

EMP NO.

GROUP

HIRE DATE

EMAIL

** Please indicate at least 1 phone number

optional

	NAME (Last, First)	DOB	Social Security Number	Gender	Check Boxes for COVERAGE *			Add / Term
					Med/Rx	Dent	Vis	
Employee								
Spouse								
Dependent								
Dependent								
Dependent								
Dependent								
Dependent								

EMPLOYEE SIGNATURE: _____ DATE: _____

* If declining both Medical AND Dental coverage, you must complete the Health Insurance Waiver Form to be entitled to a Health Waiver Payment.

Please do not complete below - For Payroll & Insurance Use only

	Med	Dent	Vision	Notes
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Retiree/Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Decline Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	