SWSCHP - ANTHEM / BCBS

EMPLOYEE BENEFITS ENROLLMENT FORM

SOCIAL SECURITY NO.	CELL PHONE	EMAIL ADDRESS:
- -		

NAME (LAST. FIRST, M.I.)	ADDRESS (STREET. CITY. STATE, ZIP CODE)

DATE OF BIRTH	SEX	MARITAL STATUS (Married, Single. Divonced. Widow,Legally Sep.)	MARRIAGE DATE	DO YOU HAVE MEDICARE COVERAGE:	IF YES, CHECK	EFFECTIVE DATES	MEDICARE ID NO.	EMPLOYMENT DATE
					☐ Part A	/ /	☐ Part B / /	/ /

IF YES, NAME OF OTHER CARRIER/ GROUP NO.		

SPOUSE ☐ DOMESTIC PARTNER ☐	NAME (LAST, FIRST. M.I.)	/ /	SEX	DISABLED	MEDICARE COVERAGE7	IF YES, CHECK	EFFECTIVE DATES	SOCIAL SECURITY NO.
						☐ PART A / /	☐ PARTB / /	

EMPLOYED:	IF YES, NAME OF EMPLOYER	OTHER GROUP HEALTH INSURANCE:	IF YES. TYPE OF COVERAGE	EFFECTIVE DATE OF COVERAGE	STATUS OF EMPLOYMENT
			☐ INDIVIDUAL ☐ FAMILY	/ /	ACTIVE RETIRED

NAME OF CARRIER	ADDRESS (SmEET, CITY, STATE, ZIP CODE)	PHONE NO.	GROUP NO.

List Dependents Below:

RELATIONSHIP TO EMPLOYEE	LAST NAME	First Name	MI.	SOCIAL SECURITY NO.	SEX	BIRTH DATE	DISABLED	STUDENT DEP.
						/ /		
						/ /		
						/ /		
						/ /		
						/ /		

TYPE	OPTION	SINGLE FAMILY	CODE	EFFECTIVE DATE	CANCELLATION DATE
	SWS HEALTH PLAN				

MAKE ANY REQUIRED PAYROLL DEDUCTIONS.	DATE	EMPLOYER'S REPRESENTATIVE	DATE

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