# ENROLLMENT FORM

GROUP NAME _____ **GROUP NUMBER** _____ **LOCATION:** _____

## EMPLOYEE INFORMATION

EMPLOYEE'S NAME: _____ - _____ - _____
FIRST MIDDLE LAST

EMPLOYEE'S SEX: MALE / FEMALE

EMPLOYEE'S MARITAL STATUS: SINGLE / MARRIED / SEPARATED

EMPLOYEE'S SOCIAL SECURITY NUMBER: _____-_____-_____

CURRENT ADDRESS: _____

_____

City , State , Zip _____, _____ _____

| □ Medical | □ Dental |
|---|---|
| □ E □ ES □ EC □ FF | □ E □ ES □ EC □ FF |

Date of Birth _____M_____D_____Y

Home Phone ( )-_____-_____

Date of Hire_____Effec. Date_____basic earnings$_____ Hrly. Wkly. Mo. Yrly.

Termination Date_____

Name of beneficiary_____relationship_____

## DEPENDENT INFORMATION: FEDERAL MANDATE REQUIRES SS NUMBER FOR DEPENDENTS

***IS DEPENDENT COVERAGE REQUESTED?_____Yes_____No***

Complete this section only if you are applying for dependent coverage. List spouse and unmarried dependent children. ( If additional Space is required, attach a separate sheet. )

| NAME | S.S.Number | Date of Birth | Sex | Relationship | Both / Medical /Dental |
|---|---|---|---|---|---|
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## OTHER INSURANCE INFORMATION

Is your spouse or any of your dependents covered under any other Medical or Dental coverage? _____

(this includes student insurance, Medicare and Champus)

If YES, please list the following: Is it Medical or Dental coverage? _____

Name of Policy Holder _____

Insurance Carrier _____ Policy Number _____

Name(s) of covered dependents _____

I request insurance under my Employer's Group Plan, as now or hereafter to me, and authorize the deductions, if any to pay my share of the cost.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM.

**EMPLOYEE'S REFUSAL SIGNATURE**_____**DATE**_____

**EMPLOYEE'S SIGNATURE** _____ **DATE** _____