

CYPRESS BENEFIT ADMINISTRATORS – ENROLLMENT FORM

PO Box 7020 Appleton, WI 54912

Phone: 877-236-0844

Fax: 866-542-1874

GROUP NAME:

GROUP#

Employer Section:

Date of Hire _____

Division _____

Effective Date _____

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	MALE / FEMALE
STREET ADDRESS		MARITAL ☐ Single ☐ Divorced STATUS: ☐ Married ☐ Other _____	DATE OF BIRTH	
CITY	STATE	ZIP	HOURS WORKED PER WEEK	PHONE NUMBER

COVERAGE ELECTION (Please Circle)

MEDICAL PLAN COVERAGE	SINGLE ☐	EMPLOYEE + SPOUSE ☐	EMPLOYEE + CHILD ☐	FAMILY ☐
☐ I WAIVE ALL MEDICAL COVERAGE –Please sign below.				

DEPENDENTS (enrolling in plan)

	SEX	LAST NAME	FIRST NAME	M.I.	BIRTH DATE	SOCIAL SECURITY NUMBER	OTHER INSURANCE
SPOUSE	☐ M ☐ F						If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)
CHILD	☐ M ☐ F						
CHILD	☐ M ☐ F						
CHILD	☐ M ☐ F						
CHILD	☐ M ☐ F						

OTHER COVERAGE INFORMATION

This section must also be filled out for anyone having other coverage, including Medicare coverage

Name of Covered Person	Health	Effective Date	Name of Carrier	Name of Policy Holder
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If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

(1) I am enrolling for the benefits indicated in the "Coverage Election" section. If required, I authorize deductions from my earnings. (2) By completing the "Waiver of Coverage", I understand I am refusing coverage and that there may be penalties if I decide to reapply at a later date. (3) I hereby authorize any licensed physician, hospital, clinic, or other medical or medically related facility, insurance company, the Medical information Bureau, or other organization, institution, or person, that has any records or knowledge of me and/or my dependents' health, to give to Cypress Benefit Administrators or the reinsurer any such information. (4) I also authorize Cypress Benefit Administrators or the reinsurer to release any information regarding me and/or my dependents to the Medical Information Bureau and to other carriers through which I have policies or to whom I may apply or to whom a claim for benefits may be submitted. (5) I hereby certify that all the information shown above is true and correct to the best of my knowledge. I also understand that any false information listed will nullify this application and the coverage for which I am applying. Cypress Benefit Administrators has the right to rescind coverage should the above information prove to be not complete or accurate.

Employee Signature _____

Date _____

Employer Signature _____

Date _____

Employee Name: _____

SSN: _____

[illegible]