Enrollment Form



All information must be completed to process form. Incomplete forms will be returned and not processed.

Employee information						
Employee last name			First name		Middle initial	Social Security number – –
Street address				City	State	Zip code
Home phone	Work p	hone		Gender	Birth date (month/day/year)	
()	()		Male Female	/	/
E-mail address		Race/ethnicity (opt	· = ·	Latino Asian can American Other	Marital status Divorced	d Widowed
Primary Care Physician (PCP)		PCP add	lress		Are you a current patient?	

Family information (Your spouse and eligible children you wish to enroll).							
	Spouse last name		First name		Middle initial		Social Security number
1	Birth date (month/day/year) / /	Gender	Female	E-mail address			
Spouse	Primary Care Physician (PCP)		PCP address			Are you a	a current patient?
	Race/ethnicity (optional)*		Asian	White/Caucasian	lack/African Amer	ican	Other
•	Family member last name		First name		Middle initial	Social Se	curity number -
2	Birth date (month/day/year) / /	Gender	Female	E-mail address			
Adopted child	School or family member's permanent address			City	State	Zip code	
Stepchild	Primary Care Physician (PCP)		PCP address		1	Are you a	a current patient?
Other	Race/ethnicity (optional)*		Asian	White/Caucasian B	lack/African Amer	ican	Other
	Family member last name		First name		Middle initial	Social Se	curity number -
3	Birth date (month/day/year) / /	Gender	Female	E-mail address			
Adopted child	School or family member's permanent address			City	State	Zip code	
Stepchild	Primary Care Physician (PCP)		PCP address	1	1	Are you a	a current patient?
Other	Race/ethnicity (optional)*		Asian	White/Caucasian B	lack/African Amer	ican	Other

	Family member last name		First name			Social Security number
4	Birth date (month/day/year)	Gender		E-mail address		
Natural/	/ /	Male	Female			
Adopted child	School or family member's permanent address			City	State	Zip code
Stepchild	Primary Care Physician (PCP)		PCP address			Are you a current patient?
						Yes No
Other	Race/ethnicity (optional)*				l	
	Hispanic/Latino		Asian	White/Caucasian	lack/African Ameri	can Other

To be completed by employer (form cannot be processed without this information)						
Original date of hire		For re-hire employee – Date of re-hire	Effective date			
Group number		Subgroup number				
Company name						
Company phone ()		E-mail address				
	Type Union Non-Union Salary Hourly Retiree Early retiree (under 65) Retiree (65+) Surviving spouse					
Please check all applicable boxes						
		18 months 29 months 36 months Qualifying event date:				
	Health HMO open access EPO POS open access PPO IND PPO network:					
Coverage (as applicable)	Dental Single Far			HSA HBCA		
	Health option (if applicable)	Life Life amount \$ Short-term disability \$	AD&D \$			

Authorization

Your signature is needed to let us know that you will abide by an insurance policy, a Certificate of Coverage, an Explanation of Coverage, or a Summary Plan Description that applies to our coverage.

Employee signature	Today's date
x	
Employer signature	Today's date
x	

For internal use		
Contract number	Initials	Date

Employee Name: _____

	Family member last name	First Name	Middle Initial	Social Security number				
			_					
5	Birth date (month/day/year)	Gender	E	-mail address				
	School or family member's permaner	□ Male □ Female						
□ Natural/Adopted child		il address						
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?				
□ Other				□ Yes □No				
	Race/ethnicity (optional)*		I					
	🗆 Hispanic/Latino 🛛 A	sian 🗆 White/Caucasian 🛛	Black/African Am	erican 🗆 Other				
	Family member last name	First Name	Middle Initial	Social Security number				
			_					
6	Birth date (month/day/year)	Gender	E	-mail address				
	Sahaalar (amily manharia na mana							
Natural/Adopted child	School or family member's permaner	it address						
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?				
□ Other				□ Yes □No				
	Race/ethnicity (optional)*							
	🗆 Hispanic/Latino 🗆 A		Black/African Arr					
	Family member last name	First Name	Middle Initial	Social Security number				
_	Birth date (month/day/year)	Gender	F	-mail address				
7		□ Male □ Female	_					
	School or family member's permanent address							
Natural/Adopted child								
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?				
□ Other				□ Yes □No				
	Race/ethnicity (optional)*							
	🗆 Hispanic/Latino 🗆 A		Black/African Am					
	Family member last name	First Name	Middle Initial	Social Security number				
8	Birth date (month/day/year)	Gender	E	-mail address				
0		Male Female						
Natural/Adopted child	School or family member's permaner	nt address						
□ Stepchild								
	Primary Care Physician (PCP)	PCP address	Are	you a current patient? □ Yes □No				
	Race/ethnicity (optional)*							
	☐ Hispanic/Latino ☐ A	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🗆 Other				
	Family member last name	First Name	Middle Initial	Social Security number				
	-							
9	Birth date (month/day/year)	Gender	E	-mail address				
J		Male Female						
Natural/Adopted child	School or family member's permaner	nt address						
□ Stepchild	Drimony Core Develotion (DOD)							
	Primary Care Physician (PCP)	PCP address	Are	you a current patient?				
□ Other	Race/ethnicity (optional)*			□ Yes □No				
	Hispanic/Latino D A	sian □ White/Caucasian □	Black/African Am	erican 🗆 Other				

Employee Name: _____

	Family member last name	First Name	Middle Initial	Social Security number			
10	Birth date (month/day/year)	Gender □ Male □ Female	E	-mail address			
Natural/Adopted child	School or family member's permaner	nt address	1				
StepchildOther	Primary Care Physician (PCP)	PCP address	Are	Are you a current patient? □ Yes □No			
	Race/ethnicity (optional)*	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🗆 Other			
	Family member last name	First Name	Middle Initial	Social Security number			
11	Birth date (month/day/year)	Gender □ Male □ Female	E	-mail address			
Natural/Adopted child	School or family member's permaner						
StepchildOther	Primary Care Physician (PCP)	PCP address	Are	you a current patient? □ Yes □No			
	Race/ethnicity (optional)*		Black/African Am	nerican 🗆 Other			
	Family member last name	First Name	Middle Initial	Social Security number			
12	Birth date (month/day/year) Gender E-mail address						
Natural/Adopted child Step shild	School or family member's permanent address Primary Care Physician (PCP) PCP address Are you a current patient?						
StepchildOther	Primary Care Physician (PCP)	PCP address	Are you a current				
	Race/ethnicity (optional)*		Black/African Am	-			
	Family member last name	First Name	Middle Initial	Social Security number			
13	Birth date (month/day/year)	Gender	E	-mail address			
 Natural/Adopted child Stepchild 	School or family member's permaner						
□ Other	Primary Care Physician (PCP) Race/ethnicity (optional)*	PCP address	Are	you a current patient? □ Yes □No			
	□ Hispanic/Latino □ A		Black/African Am				
	Family member last name	First Name	Middle Initial	Social Security number			
14	Birth date (month/day/year)	Gender	E	-mail address			
 Natural/Adopted child Stepchild 	School or family member's permaner Primary Care Physician (PCP)	PCP address	Are	you a current patient?			
□ Other	Race/ethnicity (optional)*						
	□ Hispanic/Latino □ A	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🛛 Other			

Employee Name: _____

	Family member last name	First Name	Middle Initial	Social Security number
		Conder		
15	Birth date (month/day/year)	Gender □ Male □ Female	E	-mail address
	School or family member's permaner			
Natural/Adopted child	School of Tanniy members permaner			
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?
□ Other				□ Yes □No
	Race/ethnicity (optional)*			
	🗆 Hispanic/Latino 🛛 A	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🗆 Other
	Family member last name	First Name	Middle Initial	Social Security number
	-			
16	Birth date (month/day/year)	Gender	E	-mail address
16		Male Female		
	School or family member's permaner	nt address	1	
Natural/Adopted child				
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?
□ Other				□ Yes □No
	Race/ethnicity (optional)*			
	□ Hispanic/Latino □ A		Black/African Arr	-
	Family member last name	First Name	Middle Initial	Social Security number
17	Birth date (month/day/year)	Gender	E	-mail address
	School or family member's permaner	□ Male □ Female		
□ Natural/Adopted child	School of Tamily member's permaner			
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?
□ Other				□ Yes □No
	Race/ethnicity (optional)*			
	🗆 Hispanic/Latino 🛛 A	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🗆 Other
	Family member last name	First Name	Middle Initial	Social Security number
18	Birth date (month/day/year)	Gender	E	-mail address
10		Male Female		
Natural/Adopted child	School or family member's permaner	nt address		
			1 -	
Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?
□ Other	Race/ethnicity (optional)*			□ Yes □No
	Hispanic/Latino D A	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🗆 Other
	Family member last name	First Name	Middle Initial	Social Security number
	r anniy member last hame	Thatte		Social Security Humber
	Birth date (month/day/year)	Gender	F	-mail address
19		□ Male □ Female		
	School or family member's permaner			
□ Natural/Adopted child	· · · · · · · · · · · · · · · · · · ·			
□ Stepchild	Primary Care Physician (PCP)	PCP address	Are	you a current patient?
□ Other				□ Yes □No
	Race/ethnicity (optional)*		·	
	🗆 Hispanic/Latino 🛛 A	sian 🗆 White/Caucasian 🛛	Black/African Am	nerican 🗆 Other