**Employee Benefit Systems** Third Party Administration Services

# MEDICAL, DENTAL, VISION & COBRA ENROLLMENT AND CHANGE FORM

THIS APPLICATION IS: ☐ New ☐ Change ☐ Medical ☐ Dental ☐ Vision ☐ COBRA

| EMPLOYER | DEPT NO. | EMPLOYEE NO. |
|---|---|---|
| | | |

| DATE OF HIRE | EFFECTIVE DATE | | MARITAL STATUS | SEX |
|---|---|---|---|---|
| NAME | | | ☐ SINGLE<br>☐ MARRIED | ☐ MALE<br>☐ FEMALE |
| SOCIAL SECURITY # | BIRTHDATE | EMAIL ADDRESS | | |
| STREET ADDRESS | CITY | STATE | ZIP | |

THIS REQUEST FOR COVERAGE IS FOR: (IF YOU CHOOSE TO WAIVE COVERAGE, PLEASE COMPLETE THE WAIVER AT THE BOTTOM OF THE PAGE)

| | | | | | |
|---|---|---|---|---|---|
| MEDICAL: | ☐ SINGLE | ☐ EMPLOYEE/SPOUSE | ☐ EMPLOYEE/CHILD(REN) | ☐ FAMILY | ☐ WAIVE COVERAGE |
| DENTAL: | ☐ SINGLE | ☐ EMPLOYEE/SPOUSE | ☐ EMPLOYEE/CHILD(REN) | ☐ FAMILY | ☐ WAIVE COVERAGE |
| VISION: | ☐ SINGLE | ☐ EMPLOYEE/SPOUSE | ☐ EMPLOYEE/CHILD(REN) | ☐ FAMILY | ☐ WAIVE COVERAGE |
| COBRA: | ☐ SINGLE | ☐ EMPLOYEE/SPOUSE | ☐ EMPLOYEE/CHILD(REN) | ☐ FAMILY | ☐ WAIVE COVERAGE |

PLEASE LIST ELIGIBLE DEPENDENTS BELOW:

| NAME | SOCIAL SECURITY # *(required)* | BIRTHDATE MO. | DAY | YR. | SEX |
|---|---|---|---|---|---|
| SPOUSE | | | | | ☐ Male<br>☐ Female |
| CHILD | | | | | ☐ Male<br>☐ Female |
| CHILD | | | | | ☐ Male<br>☐ Female |
| CHILD | | | | | ☐ Male<br>☐ Female |
| CHILD | | | | | ☐ Male<br>☐ Female |

| OCCURANCES AFFECTING CONTRACT BENEFITS | NAME OF AFFECTED PARTY | DATE OF EVENT |
|---|---|---|
| ☐ MARRIED ☐ DIVORCE ☐ ADD/CONTINUE ADULT CHILD (include information above)<br>☐ DEATH ☐ BIRTH<br>☐ OTHER please explain: ____ | | |

## COORDINATION OF BENEFITS WITH SPOUSE'S MEDICAL, DENTAL, VISION & COBRA INSURANCE (IF APPLICABLE)

If your spouse or anyone named on this application has medical, dental or vision insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete the following.

| | EFFECTIVE DATE |
|---|---|
| NAME | EMPLOYER |
| INSURANCE COMPANY NAME | POLICY # WITH INSURANCE COMPANY |
| INSURANCE COMPANY ADDRESS | CONTRACT TYPE<br>☐ Single ☐ Family |

## WAIVER

I certify that I have been informed that an employer sponsored Group Health Care Benefit is available to me through my employer. I have voluntarily waived ☐ Medical ☐ Dental ☐ Vision coverage ☐ COBRA.

I HEREBY REQUEST to be enrolled and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the Group Policy or Policies issued. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Plan.

SIGNATURE ____________________ DATE ____________________

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