

Coverage - Please verify with your employer which plans are available .
Check all boxes that apply.



Employee	Dependents	Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Vision

Please print clearly when completing the Enrollment Form and return it to your Benefit Coordinator

Group/ Employer Name	Group No.	Effective Date	Date of Hire
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Subscriber's Information

Last Name	First Name	MI	Subscriber SS#	
Home Address				Apt. #
City		State	Zip	
Male / Female	Date of Birth	Home Phone	Work Phone	Ext.

Dependent Information

Relationship	Last Name	First Name	MI	Male/ Female	Date of Birth

Other Coverage for All Enrolling Employees and Dependents

Do any persons on this application intend to continue other Group **Medical** coverage? Yes No

If yes, Name of person: _____ Insurance Company: _____

Do any persons on this application intend to continue other Group **Dental** coverage? Yes No

If yes, Name of person: _____ Insurance Company: _____

Waiver of Coverage

I have been given the opportunity to apply for group coverage, but:

- Do not choose to elect this coverage.
- Do not choose to elect coverage for my spouse.
- Do not choose to elect coverage for my child(ren)

Your Name (Please Print)	Your Signature	Date
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