

Enrollment Application



Participant Information

Last Name _____ First _____ Initial _____
 Participant ID _____ Date of Hire/Rehire _____
 Address _____ City _____ State ____ Zip _____
 Home Phone _____

Employment Information

Employer _____ Division/Location/Local _____
 Occupation _____

Insurance Information

Are you or any of your dependents covered by any other medical or dental coverage? Yes _____ No _____
 If yes, please put a check next to those who have such coverage: Yourself ____ Your Spouse ____ Children ____
 Name of Carrier _____
 Policy # _____ Type of Coverage _____
 Is member or dependent Medicare eligible? If yes, effective dates: Part A _____ Part B _____
 Medicare Eligible Last Name _____ First _____ Initial _____

Insurance Beneficiary

Name _____ Relationship to you _____

Dependents

Below, please list all dependents to be covered:
 Are you under court order to provide health coverage? Yes _____ No _____ (Attach the QCSO to this form)

	Last Name	First Name	Check One	Rel. to Employee	Date of Birth	Social Security Number
Self			Female _____ Male _____			
Spouse			Wife _____ Husband _____			
Child			Daughter _____ Son _____			
Child			Daughter _____ Son _____			
Child			Daughter _____ Son _____			
Child			Daughter _____ Son _____			

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that the failure to disclose true and accurate information may result in the immediate termination of the benefits. I understand that the benefits will not be in effect until I have satisfied the eligibility requirements for coverage under the Plan. I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical related facility, insurance or reinsurance company or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named dependents, to give to the Plan, its legal representative, management care firm, pre-certification or utilization review firm, any and all such information.

Signature _____ **Date** _____

----- *For Plan Manager Use Only* -----

Effective Date _____ Class _____ Division Code _____ Client Code _____
 Status Change _____ To: _____ Life Ins. Amount \$ _____
 Termination Date _____ COBRA: From _____ To _____