



LAST NAME OF EMPLOYEE/MEMBER	FIRST NAME	M.I.	SOCIAL SECURITY NO.
ADDRESS NUMBER & STREET		CITY	STATE ZIP CODE

SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE Mo. / Day / Year	MARITAL STATUS Sing. <input type="checkbox"/> S Mar. <input type="checkbox"/> M Div. <input type="checkbox"/> D Sep. <input type="checkbox"/> L Wid. <input type="checkbox"/> W	HOURS WORKED WEEKLY
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EMPLOYER/ORGANIZATION NAME _____ OCCUPATION OR JOB TITLE _____

**COMPLETE THE PERSONAL CARE PHYSICIAN INFORMATION BELOW
IF YOU ARE ENROLLING IN A POINT OF SERVICE (POS) PROGRAM**

EMPLOYEE FAMILY RECORD <input type="checkbox"/> YES <input type="checkbox"/> NO	I REQUEST DEPENDENT COVERAGE (CHECK ONE) → <input type="checkbox"/> YES <input type="checkbox"/> NO					
DEPENDENT'S FULL NAME & SOCIAL SECURITY NUMBER	CHECK RELATIONSHIP	BIRTHDATE	MO.	DAY	YR.	PHYSICIAN INFORMATION
NAME S.S. #	SPOUSE (SEE BELOW)* <input type="checkbox"/>					EMPLOYEE PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME S.S. #	SON DAUGHTER	NATURAL CHILD STEP CHILD				SPOUSE PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME S.S. #	SON DAUGHTER	NATURAL CHILD STEP CHILD				DEPENDENT PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME S.S. #	SON DAUGHTER	NATURAL CHILD STEP CHILD				DEPENDENT PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME S.S. #	SON DAUGHTER	NATURAL CHILD STEP CHILD				DEPENDENT PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME S.S. #	SON DAUGHTER	NATURAL CHILD STEP CHILD				DEPENDENT PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME S.S. #	SON DAUGHTER	NATURAL CHILD STEP CHILD				DEPENDENT PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO

HAVE YOU SEEN THIS PHYSICIAN WITHIN 3 YEARS?
IF NO, CONTACT THE PHYSICIAN'S OFFICE TO VERIFY THAT HE/SHE IS ACCEPTING NEW PATIENTS. YES NO

* IS YOUR SPOUSE EMPLOYED? YES NO
 * IS SPOUSE ELIGIBLE FOR INSURANCE THROUGH AN EMPLOYER? YES NO
 * HAS SPOUSE ELECTED COVERAGE THROUGH AN EMPLOYER? YES NO
 * IF YES, NAME AND ADDRESS OF SPOUSE'S EMPLOYER: _____

IF YOU HAVE A CHILD/CHILDREN WHOSE HEALTH INSURANCE COVERAGE IS MANDATED BY DIVORCE DECREE OR PATERNITY ORDER, PLEASE ANSWER THE FOLLOWING:
 * WHO IS RESPONSIBLE FOR HEALTH CARE COVERAGE FOR CHILDREN LISTED?
 FATHER MOTHER BOTH OTHER
 * WHO HAS PHYSICAL CUSTODY?
 FATHER MOTHER OTHER

TO BE COMPLETED BY EMPLOYER

NEW CARD CHANGE (Circle Item)

GROUP #	LOCATION #	
HIRE DATE Mo. / Day / Year	TERM. DATE Mo. / Day / Year	
REHIRED Mo. / Day / Year	RETIRED Mo. / Day / Year	
LAI D OFF Mo. / Day / Year	OTHER	
TYPE	EFFECTIVE DATES	
	EE	DEP
LIFE		
ADD		
DEP. LIFE		
SUPP. LIFE		
W.I.		
LTD		
MEDICAL		
DENTAL		
VISION		
RX		

(IF EMPLOYEE/MEMBER IS ELIGIBLE FOR LIFE BENEFITS)

PRIMARY BENEFICIARY NAME (LAST, FIRST, & MIDDLE INITIAL)	PERCENTAGE	RELATIONSHIP TO EMPLOYEE
1. _____	_____ %	
2. _____	_____ %	
CONTINGENT BENEFICIARY NAME (LAST, FIRST, & MIDDLE INITIAL)	PERCENTAGE	RELATIONSHIP TO EMPLOYEE
1. _____	_____ %	

IF THE PLAN MAINTAINS A PRE-EXISTING CONDITIONS LIMITATION, YOU HAVE A RIGHT TO DEMONSTRATE CREDITABLE COVERAGE THAT WILL REDUCE THE PRE-EXISTING CONDITIONS LIMITATION PERIOD. YOU HAVE A RIGHT TO REQUEST A CERTIFICATE OF CREDITABLE COVERAGE FROM A PRIOR GROUP HEALTH PLAN OR HEALTH INSURANCE ISSUER, AND THE PLAN WILL ASSIST YOU IN OBTAINING THIS CERTIFICATE IF NECESSARY, UPON REQUEST.

I HEREBY CERTIFY THAT THE DEPENDENTS LISTED ABOVE ARE MY DEPENDENTS WITHIN THE DEFINITION CONTAINED IN THE GROUP PLAN OF MY EMPLOYER/ORGANIZATION. I AGREE TO NOTIFY THE PLAN ADMINISTRATOR IF AND WHEN THERE IS A CHANGE IN ANY DEPENDENT'S STATUS. I HEREBY REQUEST THE COVERAGE FOR WHICH I AM ELIGIBLE UNDER THE PLANS OF MY EMPLOYER/ORGANIZATION, AND I AUTHORIZE SAME TO DEDUCT ANY REQUIRED CONTRIBUTION FROM MY EARNINGS/FUNDS. I RESERVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME UPON WRITTEN NOTICE.

BY SIGNING BELOW, AS AN EMPLOYEE OR DEPENDENT, I AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BY OR TO ANY FAMILY MEMBERS, ANY HEALTH CARE PROVIDER, THE PLAN SPONSOR, THE INSURER/TPA OF THE PLAN, OR ANY OTHER ENTITY PROVIDING SERVICES IN CONNECTION WITH THE PLAN IN ORDER TO PROCESS MY ENROLLMENT IN THE PLAN OR TO PROCESS ANY CLAIM FOR MY PLAN BENEFITS. THIS AUTHORIZATION IS EFFECTIVE UNTIL THE DATE I TERMINATE ENROLLMENT IN THE PLAN. FURTHER, I HAVE READ AND I UNDERSTAND THE FOLLOWING: (1) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BEFORE ITS EXPIRATION DATE BY NOTIFYING THE PLAN IN WRITING, BUT THE REVOCATION WILL NOT HAVE ANY EFFECT ON ANY ACTIONS THE PLAN TOOK BEFORE IT RECEIVED THE REVOCATION; (2) I MAY SEE AND COPY THE INFORMATION DESCRIBED ON THIS FORM IF I ASK FOR IT; (3) I AM NOT REQUIRED TO SIGN THIS FORM TO RECEIVE MY HEALTH CARE BENEFITS (ENROLLMENT, TREATMENT, OR PAYMENT); AND (4) THE INFORMATION THAT IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE RE-DISCLOSED BY THE RECEIVING ENTITY.

EMPLOYEE SIGNATURE _____ DATE _____
 Note: Please complete other side if refusing plan(s) or benefit(s).
 DEPENDENT SIGNATURE _____ DATE _____
 DEPENDENT SIGNATURE _____ DATE _____
 DEPENDENT SIGNATURE _____ DATE _____

↑ PLAN USE ONLY ↑

REFUSAL CARD

READ CAREFULLY AND COMPLETE ONLY IF YOU ARE DECLINING COVERAGE

SPECIAL ENROLLMENT RIGHT #1: If you initially decline this plan's coverage for yourself or any of your dependents (including your spouse) because of other group health coverage, you may in the future be able to enroll yourself and your dependents in this plan if application is made within 30 days after that other coverage ends.

SPECIAL ENROLLMENT RIGHT #2: If you initially decline this plan's coverage for yourself or any of your dependents (including your spouse), and you later acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan if application is made within 30 days after the marriage, birth, adoption, or placement for adoption.

I have read the above information about this plan's special enrollment rights. By signing this form, I hereby decline coverage under this plan for myself and the following dependents: _____

I decline the following plan(s): _____

I decline coverage under this plan at this time for the following reason(s):

I/We are currently enrolled for other group health coverage.

Other reason(s) as described: _____

EMPLOYEE SIGNATURE: _____

PRINTED NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE SIGNED: _____