



PLEASE PRINT CLEARLY AND BE SURE TO SIGN AND DATE THIS FORM

EMPLOYEE INFORMATION - PLEASE PRINT CLEARLY				
EMPLOYEE NAME (LAST):	(FIRST):	(INITIAL):	EMPLOYEE DATE OF BIRTH:	GROUP NUMBER:
STREET ADDRESS:		CITY:	STATE:	ZIP:
				PHONE NUMBER:
CHECK ONE: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CHECK ONE: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	CHECK ONE: <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms./Miss	EMPLOYEE SOCIAL SECURITY NUMBER:	EMPLOYEE (J) NUMBER:
TYPE OF COVERAGE SELECTED: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY				

NATURE OF APPLICATION - CHECK THE APPROPRIATE BOX FOR THE ACTION DESIRED:		
<input type="checkbox"/> NEW CONTRACT APPLICATION	<b>CHANGE CONTRACT</b>	<b>ADD/REMOVE DEPENDENT</b>
<input type="checkbox"/> CANCEL CONTRACT	<input type="checkbox"/> NAME CHANGE	<input type="checkbox"/> ADD SPOUSE
	<input type="checkbox"/> ADDRESS CHANGE	<input type="checkbox"/> ADD DEPENDENT CHILD
	<input type="checkbox"/> TYPE OF COVERAGE CHANGE	<input type="checkbox"/> REMOVE SPOUSE
	<input type="checkbox"/> CHANGE COB INFORMATION	<input type="checkbox"/> REMOVE DEPENDENT CHILD
DATE EVENT OCCURRED (Example: Date of marriage, birth date of child, date of death, etc.): _____		

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER AND/OR MEDICARE NUMBER (HICN)							
The Social Security Number for the employee and ALL dependents must be provided in order for this application to be processed.							
LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	SOCIAL SECURITY NUMBER AND/OR HIC NUMBER	DATE OF BIRTH		
					MONTH	DAY	YEAR
			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				

DEPENDENT CHILD EXTENSION CERTIFICATION - LIST ANY DEPENDENT CHILD APPLYING FOR COVERAGE AGE 19 AND OVER			
NAME OF CHILD:	IS THE CHILD EMPLOYED:		
_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
NAME & PHONE NUMBER OF EMPLOYER:	DOES THE EMPLOYER OFFER GROUP HEALTH INSURANCE:		
_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
NAME OF CHILD:	IS THE CHILD EMPLOYED:		
_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
NAME & PHONE NUMBER OF EMPLOYER:	DOES THE EMPLOYER OFFER GROUP HEALTH INSURANCE:		
_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

COORDINATION OF BENEFITS - MANDATORY INFORMATION			
If you, your spouse, or dependents are covered by any other group health insurance, you are required to provide the following information:			
NAME OF CONTRACT HOLDER:	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER:	TYPE OF COVERAGE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY	NAME OF INSURANCE COMPANY:
EMPLOYER'S NAME:	EMPLOYER STREET ADDRESS, CITY, STATE, & ZIP:	GROUP NUMBER:	COVERAGE EFFECTIVE DATE:
NAME OF MEMBER ENTITLED TO MEDICARE BENEFITS:		<input type="checkbox"/> PART A <input type="checkbox"/> PART B	MEDICARE NUMBER (HICN):

