

Reason for Enrollment/Change

Name of Affected Party _____ Date of Event ____/____/____ (mm/dd/yy)

New Hire/New Enrollee Late Enrollee Special Enrollee Loss of Coverage Marriage Birth/Adoption Death Divorce

Employment Termination COBRA Cancel Coverage (reason) _____

Other _____

Other Coverage

Medicare Coverage: Name _____ ID # _____

Effective Date (Part A) ____/____/____ (Part B) ____/____/____ (Part D) ____/____/____

Concurrent Coverage: Will you, your spouse or your dependents keep other coverage in addition to this coverage? Yes No

If yes, check all that apply. Medical Dental Vision Life Disability

Employee Employee/Spouse Employee/Child(ren) Employee/Spouse/Children

Name of covered person(s) _____

Employer (if applicable) _____

Insurance Company/HMO Name and Address _____

Policy No. _____ Effective Date ____/____/____ End Date ____/____/____

Previous Coverage: Within the last 18 months, did you have health insurance coverage? Yes No

If yes, check all that apply. Employee Employee/Spouse Employee/Child(ren) Employee/Spouse/Children

Name of covered person(s) _____

Employer (if applicable) _____

Insurance Company/HMO Name and Address _____

Policy No. _____ Effective Date ____/____/____ End Date ____/____/____

Designated Beneficiaries

Group Term Life and/or Voluntary Term Life Beneficiary Designation
 (NOTE: The same beneficiary will be used for both Group Term Life and Voluntary Term Life. If you wish to name different beneficiaries for each coverage, please ask your employer for a beneficiary change form to complete in addition to the information shown below.)
All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:			
Name and Address	Percentage	Relationship	Social Security #
Contingent Beneficiaries:			
Name and Address	Percentage	Relationship	Social Security #

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as a trustee, it is understood and agreed that the Plan shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to the Plan

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

Waiver of Coverage

I decline coverage for:

Medical Dental Vision Life Disability

Declining coverage due to existence of another coverage:

Spouse's Employer's Plan Individual Plan Medicaid

Covered by Medicare VA eligibility Tri-Care

COBRA from prior employer Other, Explain: _____

OR I (we) have no other coverage at this time

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Employee Name _____

