HEALTH PLAN ENROLLMENT/CHANGE FORM

COMPLETE ALL PERTINENT SECTIONS

EMPLOYER

NEW ENROLLMENT _____ EFFECTI VE DATE _____/_____/_____

ADDITION _____ REASON FOR ADDITION: _____ NEWLY MARRIED _____ OPEN ENROLLMENT _____ OTHER EFFECTIVE DATE _____/_____/_____

TERMINATION _____ EFFECTIVE DATE _____/_____/_____ ELECTED COBRA ? _____ QUALIFYING EVENT _____

EMPLOYEE/RETIREE INFORMATION

1. EMPLOYEE'S LAST NAME	FIRST	MI	2. PHONE-WORK	3. HOME	4. ID NUMBER	5. COVERAGE TYPE
						__ Single __ Family __ Employee/Spouse __ Parent/Child(ren)
6. ADDRESS-STREET	CITY, STATE			ZIP		
7. EMPLOYER NAME AND LOCATION (CITY AND STATE)				8. HIRE DATE	9. STATUS Active Retired	
10. MARITAL STATUS Single Married Divorced Separated						

PERSONS TO BE ENROLLED/ADDED/TERMINATED

IMPORTANT: IF YOU DO NOT ENROLL OR YOU DO NOT ENROLL ALL OF YOUR ELIGIBLE DEPENDENTS YOU WILL NOT BE ELIGIBLE UNTIL THE NEXT OPEN ENROLLMENT UNLESS YOU QUALIFY FOR SPECIAL ENROLLMENT

11. SELF - LAST NAME	FIRST	MI	12. RELATION	13. SEX	14. BIRTHDATE	15. SOC. SEC. NO.
DEPENDENT- LAST NAME	FIRST	MI	RELATION	SEX	BIRTHDATE	SOC. SEC. NO.
DEPENDENT- LAST NAME	FIRST	MI	RELATION	SEX	BIRTHDATE	SOC. SEC. NO.
DEPENDENT- LAST NAME	FIRST	MI	RELATION	SEX	BIRTHDATE	SOC. SEC. NO.
DEPENDENT- LAST NAME	FIRST	MI	RELATION	SEX	BIRTHDATE	SOC. SEC. NO.

16. DO YOU HAVE A CHILD WHO IS A FULL TIME STUDENT? __ YES __NO PLEASE ATTACH DOCUMENTATION FROM SCHOOL
17. DO YOU HAVE A DISABLED DEPENDENT CHILD? __ YES __NO PLEASE ATTACH DOCUMENTATION FROM EMPLOYER

OTHER HEALTH COVERAGE/INSURANCE/MEDICARE

IF YOU OR ANY FAMILY MEMBERS ARE COVERED BY ANOTHER HEALTH PROGRAM AND/OR MEDICARE PLEASE COMPLETE BELOW

18. INSURANCE CO./MEDICARE (PART A, B)	19. POLICYHOLDER	20. GROUP NUMBER	21. ID NO.	22. EFF. DATE	23. COVERAGE TYPE __ Single __ Family __ Employee/Spouse __ Parent/Child(ren)
24. INSURANCE CO. ADDRESS		25. PHONE NO.			

SIGNATURE

_____ _____

SIGNATURE OF APPLICANT DATE

EMPLOYER USE ONLY				MAXON USE
REASON FOR APPLICATION				
	DEPARTMENT			
	EMPLOYER SIGNATURE		DATE	