

HEALTH PLAN ENROLLMENT/CHANGE FORM

COMPLETE ALL PERTINENT SECTIONS

EMPLOYER _____	
NEW ENROLLMENT _____	EFFECTIVE DATE ____/____/____
ADDITION _____	REASON FOR ADDITION: _____ NEWLY MARRIED _____ OPEN ENROLLMENT _____ OTHER _____
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
6. ADDRESS-STREET	CITY, STATE			ZIP		<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Parent/Child(ren)
7. EMPLOYER NAME AND LOCATION (CITY AND STATE)				8. HIRE DATE	9. STATUS	
10. MARITAL STATUS						Active Retired
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? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE ATTACH DOCUMENTATION FROM SCHOOL						
17. DO YOU HAVE A DISABLED DEPENDENT CHILD? <input type="checkbox"/> YES <input type="checkbox"/> 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	
					<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> 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	