

# BENEFITS ENROLLMENT APPLICATION

SECTION 1

Your Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
 Your Social Security No. \_\_\_\_\_  
 Address \_\_\_\_\_  
 Single  Married  Separated  Divorced  Widowed  
 Date of Marriage \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Divorce \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_  
 Employment Status:  Full-time  Part-time  Active  Retired  COBRA  
 Date of Employment \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Retirement \_\_\_\_/\_\_\_\_/\_\_\_\_

**EMPLOYER USE ONLY**

Group Name \_\_\_\_\_  
 Group No. \_\_\_\_\_ Sub Group # \_\_\_\_\_  
 Effective Date Requested  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION 3**

**OTHER COVERAGE?**

Is there coverage under any other group health plan available to you or any member of your family?  No  Yes  
 If Yes; Policyholder Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Self  Spouse  Child  
 Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insurance Co. Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Address \_\_\_\_\_  
 Plan Type  Self Only  Self and Family Coverage Type  Health  Drug  Dental  Vision

SECTION 2

<input type="checkbox"/> New Enrollment/Reinstatement (complete Section 4) <input type="checkbox"/> Change Coverage from _____ to _____ (check new coverage) <input type="checkbox"/> Add Dep. to Age 29: Parent's SSN: _____ <input type="checkbox"/> Cancel Coverage: (check those that apply) <input type="checkbox"/> Add or Delete Dependent: (complete Section 4) <input type="checkbox"/> Change Enrollee's Information: REASON: _____	Type	Plan Code(s)	Individual	2 Person	Family	Complement to Medicare
	Indemnity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	POS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dental		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vision		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS**

SECTION 4	ADD	DEPENDENT	Relationship	DEPENDENT NAME				Full-Time Student	Dependent to age 26	Social Security#	Copy of Medicare card required	Medicare A & B	Disabled?	FOR CDPHP EPO AND EMPIRE PPO ENROLLMENT ONLY	
				Last	First	M.I.	Birthdate							Primary Physician - OB/GYN	Existing Patient
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self <input type="checkbox"/> M <input type="checkbox"/> F				____/____/____			____-____-____	____/____/____ ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Husband <input type="checkbox"/> Wife				____/____/____			____-____-____	____/____/____ ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____-____-____	____/____/____ ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____-____-____	____/____/____ ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	____-____-____	____/____/____ ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP OB/GYN	<input type="checkbox"/>	

SECTION 5

Do your dependents reside in your home?  Yes  No If No give address:  
 List names \_\_\_\_\_ School Name and Address \_\_\_\_\_ Expected Graduation: \_\_\_\_\_

**AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer's Signature \_\_\_\_\_  
 Date \_\_\_\_/\_\_\_\_/\_\_\_\_