EMPLOYEE ENROLLMENT FORM

CARRIER:

Enrollment Type

☐ New Hire ☐ Newly Eligible Newly Eligible Date

☐ Open Enrollment ☐ Life Event Event Name Event Date

EMPLOYER INFORMATION

Company	Group Number

EMPLOYEE INFORMATION

First Name	Last Name	Middle Name	Suffix

SSN	DOB	Gender	Tobacco User	Marital Status
		☐ M ☐ F	☐ Y ☐ N	☐ Single ☐ Married

Address	Address 2	City	State	ZIP	County

Mailing Address 1	Mailing Address 2	City	State	ZIP

Home Phone	Work Phone	Email

EMPLOYMENT INFORMATION

Date of Hire	Hours Worked	Job Title	Class
			Class 2

ENROLLMENT INFORMATION

Name	Plan Name	Coverage Level	Effective Date	End Date

DEPENDENT INFORMATION

SSN	First Name	Last Name	Middle Name	Suffix

Relationship	DOB	Gender ☐ M ☐ F	Tobacco User ☐ Y ☐ N	Disabled ☐ Y ☐ N	Disabled Start

Separate Address 1	Separate Address 2	City	State	ZIP

Effective Date	End Date

SSN	First Name	Last Name	Middle Name	Suffix

Relationship	DOB	Gender ☐ M ☐ F	Tobacco User ☐ Y ☐ N	Disabled ☐ Y ☐ N	Disabled Start

Separate Address 1	Separate Address 2	City	State	ZIP

Effective Date	End Date

SSN	First Name	Last Name	Middle Name	Suffix

Relationship	DOB	Gender ☐ M ☐ F	Tobacco User ☐ Y ☐ N	Disabled ☐ Y ☐ N	Disabled Start

Separate Address 1	Separate Address 2	City	State	ZIP

Effective Date	End Date

PRIMARY CARE PHYSICIAN

First Name	Last Name	Relationship	PCP Type ☐ Medical ☐ Dental ☐ OB-GYN

PCP #	PCP Name	PCP City	PCP State	Current Patient ☐ Y ☐ N

First Name	Last Name	Relationship	PCP Type ☐ Medical ☐ Dental ☐ OB-GYN

PCP #	PCP Name	PCP City	PCP State	Current Patient ☐ Y ☐ N

First Name	Last Name	Relationship	PCP Type ☐ Medical ☐ Dental ☐ OB-GYN

PCP #	PCP Name	PCP City	PCP State	Current Patient ☐ Y ☐ N

First Name	Last Name	Relationship	PCP Type ☐ Medical ☐ Dental ☐ OB-GYN

PCP #	PCP Name	PCP City	PCP State	Current Patient ☐ Y ☐ N

COORDINATION OF BENEFITS

Do you and/or any enrolled dependents currently have other health insurance coverage? ☐ Y ☐ N

First Name	Last Name	Relationship	Member ID

Carrier	Policy Holder Name	Policy Holder DOB	Effective Date	Termination Date

First Name	Last Name	Relationship	Member ID

Carrier	Policy Holder Name	Policy Holder DOB	Effective Date	Termination Date

First Name	Last Name	Relationship	Member ID

Carrier	Policy Holder Name	Policy Holder DOB	Effective Date	Termination Date

First Name	Last Name	Relationship	Member ID

Carrier	Policy Holder Name	Policy Holder DOB	Effective Date	Termination Date

CARRIER FORM - Knockout Questions

CARRIER FORM - Underwriting Questions

CARRIER FORM - Disclosures

SIGNATURE

Signed Name

Date Completed

Printed Name