



BENEFIT ENROLLMENT APPLICATION/INITIAL CLAIM STATEMENT

Employer Name, Group #, Loc/Div, Office Use Only, Employee Last Name, Social Security #, Phone #, Street Address, City, State, Zip, Date of Birth, Marital Status, Date of Hire, Full-Time Date, Pay, Job Title, Annual Salary

REQUEST FOR GROUP COVERAGE - CHECK BENEFITS DESIRED OR INDICATE WAIVER OF COVERAGE: Medical, Dental, Disability, Life

List EACH Dependent To Be Covered - First Name & Middle Initial - Include Last Name IF DIFFERENT than Employee's. Table with columns: Dependent Name, Relationship to Employee, Date of Birth, Social Security #, Gender, Effective Date

OTHER COVERAGE INFORMATION. Is your Spouse Employed? Your health plan coverage includes a COORDINATION OF BENEFITS provision. 1. Do you or any family members have other group? 2. Are you or any family member covered by?

CHILD CUSTODY INFORMATION. If you or your spouse have ever been divorced or legally separated, please indicate who has custody of your child(ren):

I hereby make application for or waive coverage as indicated above. I understand I will be covered under the terms of the group plan/policies sponsored by my employer. I authorize that any contribution I may be required to make for the cost of such coverage may be deducted from my earnings on a pre-tax basis, unless I specify otherwise in writing (if applicable).

I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plan(s) issued based on this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

EMPLOYEE SIGNATURE: X DATE: