



Please read and fill out **ALL** applicable sections carefully.

1. Employer Section

Please print or type.

Location Name:		Location#:	
First Active Day of Work:		Enrollment Use Only:	Effective Date of Coverage:

2. Employee Section

Employee's Last Name:		Employee's First Name:	
Employee's Home Address:			
City:	State:	Zip Code:	
Employee's Soc. Sec. #:		Date of Birth:	
Email Address:		Home Phone:	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Religious	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced

I request to be covered for the applicable benefits of my Group Plan as:

- Employee Only **OR**
 Employee and Spouse
 Employee and Child(ren)
 Employee, Spouse and Child(ren)

Please Complete section below if selecting dependent coverage.			Must be completed entirely or can result in delay.		
List the name of each dependent and answer each question for each dependent.	Social Security Number	Birthdate MM/DD/YY	Sex F/M	Are you legal Guardian	Step-child
Spouse:				N/A	N/A
List Children Below					
1.					
2.					
3.					
4.					
5.					
6.					

Signature of Employee:	Date:
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3. Waiver Of Group Coverage

I hereby certify that I have been given an opportunity to apply for group coverage. I understand that if I waive coverage at this time, future coverage may be delayed. I decline to enroll:

- Myself My Dependents for Coverage(s) because:
 Enrolled on Spouse's Plan Individual Policy Medicare Medicaid
 Enrolled with another employer plan Other (please explain _____)

Effective Date:		Signature of Employee:		Date:	
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