

Eligibility Enrollment/Update

Check: Indiana Michigan North Carolina Ohio

Client Name:

Client#/Subclient#

Subscriber Information (please complete for all enrollments/updates): Example:

Subscriber Name (Last) (First) (M.I.) Sex Male Female Status* Active Retiree COBRA Surviving

Subscriber Social Security Number Birth Date Coverage Effective Date Hire Date

Street Address Email Check here if this is a new address

City State ZIP Code

Plan Enrollment/Update Information (please indicate type of update and fill in appropriate information):

Type of Update: New Enrollment Reinstatement Change/Correction to Information Termination of Benefits Waive Benefits

Group Transfer From: Client/Subclient# To: Client/Subclient# Rate Code Change* From: To: Effective Date of Change

Change is for: Subscriber Dependent

Enrollment/Corrections to Information (please fill in for spouse/dependents for first-time enrollment or corrections):

SPOUSE Name (Last) (First) (M.I.) Sex Male Female
 Social Security Number Birth Date Status* Legal Surviving

DEPENDENT #1 Name (Last) (First) (M.I.) Sex Male Female
 Social Security Number Birth Date Status* IRS Dep. Disabled Surviving Sponsored

DEPENDENT #2 Name (Last) (First) (M.I.) Sex Male Female
 Social Security Number Birth Date Status* IRS Dep. Disabled Surviving Sponsored

DEPENDENT #3 Name (Last) (First) (M.I.) Sex Male Female
 Social Security Number Birth Date Status* IRS Dep. Disabled Surviving Sponsored

DEPENDENT #4 Name (Last) (First) (M.I.) Sex Male Female
 Social Security Number Birth Date Status* IRS Dep. Disabled Surviving Sponsored

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

1 Subscriber's Signature _____ Date