Insurance Enrollment & Change Form

☐ Initial Enrollment ☐ Dependent Change ☐ Cancel Coverage

☐ COBRA Enrollment ☐ Plan Change

Employee / Subscriber Information:

Name _____

Social Security Number_____ D.O.B. _____

Date Of Hire_____ Gender: ☐ Male ☐ Female

Street Address_____

_____

City_____ State_____ Zip Code_____

Home Phone _____ Cell Phone _____

Plan Elections:

☐ Medical (Aetna Freedom 15) ☐ Medical (Aetna Core A) ☐ Medical (Aetna Core B)

☐ Prescription (Benecard) ☐ Dental (Delta Dental) ☐ Vision (NVA)

Dependent Information: (Attach sheet to list additional children)

Spouse ☐ Add To Plan ☐ Remove From Plan

Social Security Number_____ Name_____

Date Of Birth_____ Gender: ☐ Male ☐ Female

☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Child ☐ Add To Plan ☐ Remove From Plan

Social Security Number_____ Name_____

Date Of Birth_____ Gender: ☐ Male ☐ Female

☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Child ☐ Add To Plan ☐ Remove From Plan

Social Security Number_____ Name_____

Date Of Birth_____ Gender: ☐ Male ☐ Female

☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Child ☐ Add To Plan ☐ Remove From Plan

Social Security Number_____ Name_____

Date Of Birth_____ Gender: ☐ Male ☐ Female

☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Signature_____ Date_____

Office Use Only

Effective Date_____ Date Entered_____ Initials_____

Documentation Provided ☐ Yes ☐ No