

EBMS office use only

Company Name	Group #
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This Section is to be Completed By Employee

Last Name	First Name	M.I.	Gender	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
Social Security Number			Date of Birth	
Current Mailing Address				
Street		City	State	Zip
Home Phone ()		Work Phone ()		(ext)
Life Insurance Beneficiary		Relationship	Contingent Life Beneficiary	
Addr:		SSN:	Addr:	
SSN:		SSN:		SSN:

Please Indicate the Coverage Elected for Each Dependent

List of Eligible Dependents		M.I.	Social Security #	Gender	Date of Birth	Relationship to Employee	Medical	Dental	Vision	Primary Care Physician (if applicable)
Last Name	First Name									
SELF							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other Health Benefit Information:
Please complete the following information for each person in order to coordinate benefits with other health benefit plans.

Are you or any of your dependents enrolled in another health benefit plan? Yes If yes, please indicate other insurance coverage below
If other insurance coverage (OIC) is not indicated on this enrollment form, this will imply that no other insurance coverage (OIC) is in effect.

Last Name	First Name	Other Health Benefit Name, Policy Number and Address	Medicare	Medical	Dental	Vision
SELF			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your dependent children are covered under another health benefit policy, please list the policyholder's name and date of birth below.

Other policyholder name:	Other policyholder date of birth:
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Application is made for benefits under Employer's benefit plan for which I am eligible and authorization is granted to deduct from my salary or wages any premiums required. I certified the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the plan.

Accept: If you accept coverage please sign and date below. (this form is valid only if signed and dated)	Declination: If you decline coverage for yourself and your dependents, please sign and date below.
Applicant Signature _____ Date _____	Signature _____ Date _____

This Section Is To Be Completed By Employer

Division	PPO	Plan (Deductible)
<input type="checkbox"/> Initially Eligible	<input type="checkbox"/> Open Enrollment (if applicable)	<input type="checkbox"/> Late Enrollment (if applicable)
<input type="checkbox"/> Termination - Date / /	<input type="checkbox"/> Reinstatement - Date / /	<input type="checkbox"/> Retirement
<input type="checkbox"/> Transfer from to	<input type="checkbox"/> Special Enrollment - Describe	
Change Request - Effective Date Of Change / /		
<input type="checkbox"/> Addition	<input type="checkbox"/> Newborn	<input type="checkbox"/> Deletion
<input type="checkbox"/> Marriage: Date / /	<input type="checkbox"/> Name/Address Change	
<input type="checkbox"/> Other		
Date of Hire / /	Coverage Effective Date / /	Original Medical Effective Date / /
Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> On Leave	Earnings (if applicable) \$	<input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Year
Life Insurance Amount (if applicable) \$	Dependent Life (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Life (if applicable) \$
Long Term Disability (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Certificate of Creditable Coverage: <input type="checkbox"/> Is attached for consideration <input type="checkbox"/> To be sent <input type="checkbox"/> Does not apply		

For EBMS Office Use Only: Entered by: _____	Date of Entry: _____	ID Card <input type="checkbox"/> Yes <input type="checkbox"/> No
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