



GROUP ENROLLMENT/CHANGE FORM
 P.O. BOX 45018 FRESNO CA 93718-5018
 (800) 442-7247 FAX (559) 499-2464

- New Enrollment
- Name/Address Change
- Reinstatement
- Rehire

- Annual Enrollment
- Change Enrollment
- Decline Coverage
- Termination

(Shaded area for office use only)

PART 1												EMPLOYEE INFORMATION											
EMPLOYER						PLAN CHOICE <input type="checkbox"/> EPO <input type="checkbox"/> PPO <input type="checkbox"/> STANDARD <input type="checkbox"/> OTHER			GROUP NUMBER			Benefit Type(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Life											
EMPLOYEE LAST		FIRST				MI		SS #										EFFECTIVE DATE					
		MED		DEN		VIS																	
ADDRESS STREET			CITY			STATE			ZIP CODE			HOME PHONE ()			BIRTHDATE		MO		DAY		YEAR		
HIRE DATE		JOB TITLE OR RETIRED			SALARY			<input type="checkbox"/> HRLY <input type="checkbox"/> MNLY <input type="checkbox"/> YRLY		LIFE AMT. \$		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<input type="checkbox"/> SEPARATED		DEPARTMENT			
BENEFICIARY				RELATIONSHIP				SS #		Primary Care Physician (EPO Plan only)				Physician Phone Number and Address									
EMPLOYEE TERMINATION DATE		REASON										ID CARD FORMAT		MASK									

PART 2												DEPENDENT INFORMATION											
DEPENDENT INFORMATION (List persons to be covered/terminated.): ¹ Relationship Code (relationship to participant) SPO=Spouse SON=Son DAU=Daughter DEP=Other Dependent												² Benefit Type(s): M=Medical D=Dental V=Vision Rx=Prescription											
Add/Drop	Last Name			First Name			MI	Social Security Number			Birth Date		Gender (Circle)	1 Rel. Code	2 Benefits (Circle)		Full Time Student	Disabled	Primary Care Physician (EPO Plan Only) Name Address & Phone #				
A													M F		M D V Rx		Y N	Y N					
D													M F		M D V Rx		Y N	Y N					
A													M F		M D V Rx		Y N	Y N					
D													M F		M D V Rx		Y N	Y N					
A													M F		M D V Rx		Y N	Y N					
D													M F		M D V Rx		Y N	Y N					

IF ADDING OR DROPPING DEPENDANT STATE REASON:

PART 3												OTHER INSURANCE INFORMATION											
ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO												IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached. <input type="checkbox"/>											
Name of other policy holder		Birth Date		Social Security Number		³ Rel. Code	Sponsoring Employer			Insurance Carrier or Medicare			Group Number		⁴ Benefit Types		⁵ Policy Types		Coverage Date(s)				
																			Begin / / End / /				

PERSONS COVERED UNDER ABOVE POLICY:

³ Relationship Code (specify relation to participant): SPO=Spouse OTH=Other | ⁴ Benefit Type(s): M=Medical D=Dental V=Vision Rx=Prescription | ⁵ Policy Type(s): IND=Individual Policy GRP=Group Plan HMO=Health Maintenance Organization MED=Medicare

PART 4												COVERAGE DECLINATION													
To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;																									
HEALTH PLAN COVERAGE (CHECK IF DECLINED)												REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)													
I decline coverage for:																									
<input type="checkbox"/> Myself		<input type="checkbox"/> Children		<input type="checkbox"/> Spouse		<input type="checkbox"/> Spouse and Children		<input type="checkbox"/> Covered by spouse's group coverage						<input type="checkbox"/> Spouse covered by employer's group medical coverage						<input type="checkbox"/> Medicare <input type="checkbox"/> Other (explain) _____					
I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.																									
If declining coverage for employee/dependent(s) please sign here. _____												Date _____													

PART 5												DECLARATION											
<input type="checkbox"/> I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.																							
Employee's Signature _____												Date _____											