

A. Employee Information

P L E A S E P R I N T

Social Security Number	Last Name	MI	First Name	Area Code/Home Phone ()		
Street Address ~ check if new		City		State	Zip Code	Current Marital Status (circle one) ~ Single ~ Married ~ Widowed ~ Divorced
Spouse Social Security Number	Spouse Last Name	MI	First Name	Spouse Date of Birth		
Does your Spouse work Full time? ~ Yes ~ No	Spouse Employer	Spouse Employer Address		Spouse Employer Phone ()		

B. Is your Spouse eligible for Medical Coverage from his/her employer ? (circle one) ~Yes ~No

C. Other Health Plan Information. Are you, your spouse, or any dependents covered under another Health Plan, including Medicare? (circle one) ~Yes ~No

Name of other plan	Plan Group Number	Plan Policy Number	Coverage Type: (circle one) ~Single ~Two Person ~Three or more
Street Address			Circle all that apply:
City, State, Zip			~ Medical ~ Dental ~ Prescription Drug ~Vision ~Medicare Disability ~ Medicare ESRD

List All Persons Covered under other Health Plan

	Last Name	First Name	MI	Social Security Number	Sex	REL code*	Date of Birth	Policy eff. Date	Policy end date	Medicare Effective Date		
											Part A	Part B
Spouse												
Dep 1												
Dep 2												
Dep 3												
Dep 4												
Dep 5												
Dep 6												

* Relationship codes: B - Spouse C - Natural Child/Adopted Child L - Legal Guardian P - Step Child T - Disabled D - Sponsored Dependent

D. Do you have a child / children covered by any other Health Care Coverage through Court Order (divorce or separation)? ~ Yes ~ No

By Court Order, who is responsible for Health Care Coverage for the Child / Children listed below:				Employer Name					
Person responsible for Child's coverage (First, Last)		Social Security Number		Birth Date		Group / Policy Number		Carrier Name	
Street Address				City, State, Zip					
Child 1 (First Name, Last Name)			Child 2 (First Name , Last Name)			Child 3 (First Name, Last Name)			