EMPLOYEE ENROLLMENT FORM

EBA&M
EMPLOYEE BENEFITS
ADMINISTRATION & MANAGEMENT

FOR EMPLOYER USE ONLY:	FOR EBA&M USE ONLY:
Date of Hire:	Effective Date:
Annual Earnings:	O HIPAA SPECIAL ENROLLEE
O Hourly O Salary	O LATE ENROLLEE

EMPLOYER INFORMATION

Employer's Name	Group #	Location #

EMPLOYEE INFORMATION

Employee's Last Name	First	Middle Initial	Employee's Social Security #

Home Address (Number and Street)	City	State	Zip Code

Date of Birth (MM/DD/YY)	Sex	Plan	Marital Status
	O Male O Female	O EPO/Open Access O Life Only O PPO/Indemnity	O Single O Married O Divorced O Separated O Widowed

Check appropriate boxes, then complete entire form.

O NEW EMPLOYEE O REINSTATEMENT OF EMPLOYMENT O ANNUAL ENROLLMENT

O EMPLOYEE REFUSAL OF COVERAGE:

I WAIVE COVERAGE under my employer's group insurance plan for: O Myself and my dependents O My Spouse O My children

DUE TO THE FOLLOWING REASON: O Covered under another health plan O Other, please specify reason: _____

O CHANGE EXISTING COVERAGE:

- O Name / SS# - Former Name or SS# _____
- O Address
- O Beneficiary Change
- O Add / Remove Dependents - List dependents in "DEPENDENT INFORMATION" Section below.

Check reason for change and give date of event below.

- O Marriage or Divorce / Legal Separation O Birth / Adoption O Loss of Other Coverage
- O Child reached maximum age for eligibility O Child no longer eligible
- O Other, specify _____

DATE OF EVENT checked above (MUST be completed for coverage to be added): _____

DEPENDENT INFORMATION (List dependents to be covered / terminated).

If additional space is needed, complete and attach additional forms. Check if additional form is attached O

ADD / DROP (circle one)	Last Name	First	Dependent SS#	Sex	Date of Birth	Relationship
Add / Drop						
Add / Drop						
Add / Drop						
Add / Drop						
Add / Drop						

COVERAGE DESIGNATION

Coverage	Life	Medical	Dental	Vision	Other
Employee	O	O	O	O	O
Spouse	O	O	O	O	O
Children	O	O	O	O	O

OTHER HEALTH INSURANCE INFORMATION

Do you or any of your dependents carry any other health insurance?

O Yes O No

If Yes, please list who is covered and the name of the Insurance Company:

DESIGNATION OF BENEFICIARY - Please complete only if life insurance is administered by EBA&M

Beneficiary Last Name	First	Beneficiary SS#	Relationship to Employee

Beneficiary Address Number and Street	City	State	Zip Code

EMPLOYEE SIGNATURE

PLEASE READ BELOW BEFORE SIGNING:

1. I make the above nomination of beneficiary with respect to all Life / AD&D benefits provided now or at any time in the future (thereby revoking prior nominations for such coverage, if any) still reserving to myself the privlege of making other future beneficiary changes subject to the plan provisions and upon written notification to my employer.
2. I accept the insurance provided by my employer and authorize deductions from my earnings of the required contributions, if any, toward the cost of coverages.
3. I understand that if the above information is not complete or correct, this coverage could be retroactively terminated.
4. I understand that if I decline coverage now and later want to enroll myself or my dependents, I may only be able to add coverage for myself or my dependents if I enroll for coverage within 30 days of a HIPAA Special Enrollment Event (see benefit booklet for details).

_____ Signature of Employee

_____ Date

(SIGNATURE AND DATE ARE REQUIRED FOR ENROLLMENT TO BE PROCESSED)