EMPLOYEE ENROLLMENT / CHANGE FORM

MaxMed105

EMPLOYER INFORMATION

EMPLOYER'S NAME	Group #	Date of Hire	Effective Date

EMPLOYEE INFORMATION

LAST	FIRST	MI	DATE OF BIRTH (MM/DD/YY)

HOME ADDRESS (Number and Street) (City) (State and Zip Code)

SOCIAL SECURITY NUMBER	SEX	PLAN CHOICE (If Member has a choice between plans)
	□ MALE □ FEMALE	

CHECK APPROPRIATE BOXES, THEN COMPLETE ENTIRE FORM

☐ NEW EMPLOYEE ☐ INITIAL ENROLLMENT

☐ CHANGE EXISTING COVERAGE:

- □ NAME/SS# - FORMER NAME OR SS# _____
- □ ADDRESS
- □ BENEFICIARY CHANGE
- □ ADD/REMOVE DEPENDENTS – List dependents in "DEPENDENT INFORMATION" Section below.
  - Check reason for change and give date of event below.
  - □ Marriage or Divorce / Legal Separation □ Birth / Adoption □ Loss of Other Coverage
  - □ Child reached maximum age for eligibility □ Child no longer eligible □ Other, specify _____

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

☐ EMPLOYEE REFUSAL OF COVERAGE: I WAIVE COVERAGE under my employer's group insurance plan for: □ MYSELF □ MY SPOUSE

□ MY CHILDREN DUE TO THE FOLLOWING REASON: □ COVERED UNDER ANOTHER HEALTH PLAN □ OTHER _____

DEPENDENT INFORMATION

(Circle One)	Last Name First	Dependent SS#	Sex M/F	Date of Birth	Relationship
Add / Drop					
Add / Drop					
Add / Drop					
Add / Drop					
Add / Drop					

COVERAGE DESIGNATION

Coverage	Medical	Dental	Vision
EMPLOYEE	☐	☐	☐
SPOUSE	☐	☐	☐
CHILDREN	☐	☐	☐

OTHER HEALTH INSURANCE INFORMATION

Do you or any of your dependents carry any other health insurance? ☐ Yes ☐ No

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

EMPLOYEE SIGNATURE

PLEASE READ BELOW BEFORE SIGNING:

1. I understand that if the above information is not complete or correct, this coverage could be retroactively terminated.
2. 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 (SIGNATURE AND DATE ARE REQUIRED FOR ENROLLMENT TO BE PROCESSED) Date