Medical Insurance Enrollment/Change Form

Section A. Employee Information

Complete this section with all of the requested information about yourself (the employee applying for coverage). Please print clearly.

Section B. New Enrollment, Change or Cancellation

Complete this section and mark either New Enrollment or Change. Insurance for newly hired employees become effective the first day of the month following the date of hire.
To add or remove a dependent we must have this form no later than the 14th of the month.
To remove a spouse you must have their signature or a copy of a divorce decree.

Section C. Dependent/s Information

Complete this section will all of the requested information about your dependents(s).

- If your dependent child is older than 26 and is eligible for coverage due to a physical or mental disability, you must provide proof of the dependent's disability.
- If your spouse is added, he or she may only be deleted from your coverage in the following circumstances:
  - During open enrollment
  - With proof of a legal divorce or annulment
  - With the signature of the spouse on this form

Section D. Previous Insurance Coverage with in last 12 months

List for EACH person person(s) on this application any health insurance coverage (including Medicare or Medicaid) in effect within 12 months prior to the proposed effective date of this coverage

Insurance Benefits Enrollment/Change Form

HR Use Only
_____SH
_____DD
_____VSP
_____J
_____PS

Section A. Employee Information

Employee's Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Social Security Number: _____ Sex: ☐M ☐F

Marital Status: ☐ Single ☐ Legally Married ☐Widowed

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone:_____

Section B. New Enrollment, Change or Cancellation

☐ New Enrollment Date Of Hire: _____ Effective Date: _____

Change:

☐ Add Dependent(s) ☐ Cancel Dependent(s) Name(s) _____

☐ Cancel Spouse - Name:_____ Signature of Spouse:_____

Change due to: Effective date of change: _____

☐ Birth/Adoption ☐ Marriage ☐ Loss of other coverage ☐ No longer eligible

☐ Divorce ☐ Death ☐ Open Enrollment ☐ Other_____

Section C. Dependent/s Information

	Name	SS#	Date of Birth	Relationship
Spouse				
Children				
Children				
Children				
Children				
Children				

Section D. Previous Insurance Coverage with in last 12 months

	LEGAL Name	INSURANCE Name & Policy Number	Date of Coverage	Will Coverage Continue
Insured			From:_____ To: _____	☐ Yes ☐ No
Spouse			From:_____ To: _____	☐ Yes ☐ No
Children			From:_____ To: _____	☐ Yes ☐ No
Children			From:_____ To: _____	☐ Yes ☐ No
Children			From:_____ To: _____	☐ Yes ☐ No
Children			From:_____ To: _____	☐ Yes ☐ No
Children			From:_____ To: _____	☐ Yes ☐ No

I hereby apply for enrollment, change or cancellation of coverage as indicated above. I understand any coverage will be under the master contract between Select Health, Delta Dental and VSP and my employer and I agree to the terms and conditions of that master contract.

Employee's Signature: _____ Date: _____