



Employee Insurance Enrollment Form

To speed the enrollment process please be thorough and fill out all sections that apply.

Requested Effective Date of Coverage:
Date of Change:

Salary:

Date of Hire:

Position Title:

Reason For Application

New Hire

Dependent Add / Delete

Termination

Hours Worked per week:

Annual Open Enrollment

COBRA

Loss of Coverage

Cancellation

A. EMPLOYEE INFORMATION

Last Name _____ **First Name** _____ **Social Security Number** _____ **Home Phone** _____
Work Phone _____

Address _____ **Apt #** _____ **City** _____ **State** _____ **Zip Code** _____ **Email Address** _____

Date of Birth _____ **Gender** M F Single **Marital Status** Married Divorced Widowed Domestic Partner

B. FAMILY INFORMATION

Relationship	Last Name	First Name	Date of Birth	Gender	Social Security Number
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Spouse

Dependent

Dependent

Dependent

Dependent

C. PRODUCT SELECTION – Please check all that apply

Coverage	Medical (Choose one plan)		Dental (Choose one plan)		Vision	Voluntary Benefits			
	Option A	Option B	Option A	Option B	EMI	MetLife			Info Armor
	HSA Preferred	Traditional PPO	EMI	HealthSmart	Vision	Accident	Critical Illness	Hospital Indemnity	Id Theft
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two Party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER INSURANCE

Do you or any family member have other:
 Medical Yes No Carrier _____ Policy Holder _____
 Dental Yes No Carrier _____ Policy Holder _____

F. BASIC LIFE BENEFICIARY INFORMATION

Full Name	Address	Relationship	Date of Birth	Percentage
_____	_____	_____	_____	_____%
_____	_____	_____	_____	_____%
_____	_____	_____	_____	_____%

G. SIGNATURE

I authorize the contracted insurance companies (C.I.C.), UMR, EMI and HealthSmart to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drugs, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to (C.I.C.). I understand the purpose of the disclosure and use of my information is to allow (C.I.C.) to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand the authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke the authorization at any time by notifying my (C.I.C.) representative in writing, except to the extent that action is already been taken in reliance on this authorization. As required by HIPAA, (C.I.C.) also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

Date _____ **Employee Signature** _____