# ENROLLMENT/CHANGE OF STATUS FORM
**Please Print Using Black Ink**

## SECTION A: QUALIFYING EVENT (Member Please Check One)

❑ New Hire/Open Enrollment ❑ Termination (Date): ____________

❑ Add/Delete Dependents: (Indicate Date of Qualifying Event) Complete Section C

Marriage: ____________ Birth: ____________

Divorce: ____________ Adoption: ____________

Other: ____________ Name Change: ____________

❑ Address Change

❑ Reason for Termination? ____________

❑ Decline Coverage (Complete Sections A, B, D, E)

ADMINISTERED BY:
PROFESSIONAL BENEFIT SERVICES, INC.
2255 N 44TH STREET, SUITE 250
PHOENIX, ARIZONA 85008
1-866-365-9198
FAX 602-914-9239

**Coverage Selected:**
○ Employee ○ Employee & Spouse
○ Employee & Child ○ Employee & Family

☐ Medical Plan A

☐ Medical Plan B

☐ Medical HDHP

☐ Dental

## SECTION B: MEMBERSHIP INFORMATION

Social Security Number [ ][ ][ ] — [ ][ ] — [ ][ ][ ][ ]

Single❑ Married ❑ Divorced ❑ Gender: Male ❑

Date of Birth ____ / ____ / ____ Female ❑

Employer ____________ Position/Title ____________ Date of Hire ____________

Last Name ____________ First ____________ M.I. ____________

Home Address (Mailing) ____________ City ____________ State ____________ Zipcode ____________

## SECTION C: DEPENDENT INFORMATION

| Add | Change | Delete | Last Name (if different), First, M.I. | Social Security Number | Relationship to Member | Gender | Date of Birth |
|---|---|---|---|---|---|---|---|
| | | | (Spouse) | | | M/F | |
| | | | (Child) | | | M/F | |
| | | | (Child) | | | M/F | |
| | | | (Child) | | | M/F | |
| | | | (Child) | | | M/F | |

## SECTION D: DUAL/OTHER COVERAGE

Is there any other Group Insurance for your family members? Yes ❑ No ❑

If yes, Name of Policyholder ____________, Policyholder's Date of Birth ____________

Please list dependents covered by this policy ____________

Name of Insurance Company/TPA: ____________ Address ____________

Plan/Policy Number ____________ Phone ____________

Name of Employer

## SECTION E: WAIVER OF COVERAGE

**After a complete explanation of the health plan, and after careful consideration, I am waiving ALL benefit coverage for:** ***(Check all that apply)***

○ Employee ○ Spouse ○ Children

Reason: ____________

**If you or your dependents fail to elect or refuse enrollment and decide to enroll for coverage under this plan at a later date, benefits may be deferred for a specified period of time to be determined by your employer. (Schedule D must be completed)**

## SECTION F: LIFE BENEFIT REVOCABLE BENEFICIARY

| Last Name, First, Middle Initial | Relationship to Employee | Percentage |
|---|---|---|
| Primary Beneficiary: | | |
| Additional Primary Beneficiary (if applicable): | | |
| Secondary Beneficiary: | | |

DISCLAIMER INFORMATION: I represent that all answers given are full, complete and true to the best of my knowledge, information and belief.

AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my employer or Professional Benefit Services, Inc. all information on my behalf including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be covered. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original.

AUTHORIZATION FOR PAYROLL DEDUCTION: I hereby authorize my Employer to deduct any health insurance premium that may be due from my paycheck.

Employee Signature ____________ Date ____________

**FOR YABC USE ONLY– DO NOT WRITE BELOW THIS LINE**

**DATE OF HIRE:** **EFFECTIVE DATE:**

EMPLOYER/ADMINISTRATOR SIGNATURE: ____________ Date: ____________