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

EMPLOYER/ADMINISTRATOR SIGNATURE:

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Delevance   Adoption   State   Security Number   Date of Plant														☐ Medical Plan			
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□ Resinos for Termination? □   Coverage Selected: □ Employee & Spouse □ Dental □ Destino Coverage (Complex Section A, B, D, F) □ Dental □ Destino Coverage (Complex Section A, B, D, F) □ Dental □ Destino Coverage (Complex Section A, B, D, F) □ Dental □ Destino D								ii massaanasii—ta				1	FAX 002-914-9239				☐ Medical HDH
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Social Security Number    Single   Married   Divorced   Gender: Male   Female		Decline	Coverag	e (Complete	e Sectio	ns A, E	3, D, E)										☐ Dental
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Employer Position/Title Date of Birth   Female    Employer Position/Title Date of Hire  Last Name First M.1.  Home Address (Mailing) City State Z/pcode  SECTION C: DEPENDENT INFORMATION  Add Change Debae Last Name (if different), First, M.1.  Social Security Number Relationship Gender Date of Birth Mile Childs   Mile    Childs   Childs   Mile   Mile    Childs   Mile   Childs   Mile    Childs   Mile   Mile    SECTION D: DUAL/OTHER COVERAGE  Is there any other Group Insurance for your family members? Yes   No    If yes, Name of Foliophoider   Policyholder's Date of Birth    Please list dependents covered by this policy    Name of Insurance CompanyTPA: Ad-  PlanaPolicy Number   Phone    Name of Employer    SECTION E: WALVER OF COVERAGE    If you or your dependents fall 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. (Schodule D must be completed)  SECTION F: LIEE BENEFIT REVOCABLE BENEFICIARY  Last Name, First, Middle Initial Relationship to Employee Percentage Primary Beneficiary; (i applicable).  SECTION To RELEASE BENEFIT REVOCABLE BENEFICIARY  Last Name, First, Middle Initial Relationship to Employee Percentage Primary Beneficiary; (i applicable).  SECTION To RELEASE BENEFIT REVOCABLE BENEFICIARY  Last Name, First, Middle Initial Relationship to Employee Percentage Primary Beneficiary; (i applicable).  SECTION TO RELEASE BENEFIT REVOCABLE BENEFICIARY  Last Name, First, Middle Initial Relationship to Employee, set he apply to me or my dependents and active and a first one of the proper of the situation of the primary Beneficiary; (i applicable).  SECTION TO RELEASE BENEFIT REVOCABLE BENEFICIARY  Last Name, First, Middle Initial Relationship to Employee Percentage Primary Beneficiary; (i applicable).  SECTION TO RELEASE BENEFIT REVOCABLE BENEFICIARY Relationship to Employee Percentage Primary Beneficiary; (i applicable).  SECTION TO RELEASE BENEFIT REVOCABLE BENEFIT REVOCABL	Soci	al Securi	tv Numb	ner					- I	_		2) <u>204</u> 5		AND AND ADDRESS OF THE PARTY OF			Gender: Male 🗆
Last Name First M.I.  Home Address (Malling) City State Zipcode  SECTION C: DBPENDENT INFORMATION  Add Chasgs Dalese Last Name (if different), First, M.I. Social Security Number Relationship to Member MIF Childs Childs Childs MIF C			,			İ				und und p	1 1			Date of Bi	rth/	1	Female 🗆
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Child   Child   M/F	Add	Change	Delete		e (if dif	ferent)	), First, M	I,I.				Soci	al Secu	rity Number		Gender	Date of Birth
Child   M/F   M/F				(Spouse)												M/F	
SECTION D: DUAL/OTHER COVERAGE  If yes, Name of Policyholder group finsurance for your family members? Yes Delicyholder's Date of Birth Please list dependents covered by this policy Mame of Insurance Company/TPA:    Add-  Address   Add-  Address			(Child)	**		J.							300		M/F		
Child   Child   M/F			6.0336	(Child)				A6001.0 - 500			200	22.00			<del>at la mu</del> te le	M/F	
SECTION D: DUAL/OTHER COVERAGE  Is there any other Group Insurance for your family members? Yes \( \) No \( \) If yes, Name of Policyholder's Date of Birth			CALLED VICE	(Child)			de exercise da des				********			12247			
SECTION D: DUAL/OTHER COVERAGE  Is there any other Group Insurance for your family members? Yes \( \) No \( \)    If yes, Name of Policyholder's Date of Birth  Please list dependents covered by this policy  Name of Insurance Company/TPA:  Address  Plan/Policy Number  Phone  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  Casson:  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 E: LIEE BENEFIT REVOCABLE BENEFIC CLARY  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 permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my permission to: any physician or other medical practitioner, hospital, clinic, phar	<u> </u>		25	(Child)													
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Name of Insurance Company/TPA:													Policyl	10lder's Date	of Birth		<del>*****</del> *
Plan/Policy Number															2.0		
SECTION 5: 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	dress	e of Insu	rance C	ompany/TP									_ Ad-				
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O Employee O Spouse O 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 BENIFICIARY  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	SE	CTION	VE: V	AIVER	OF (	EOV	ERAG	E.									
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