

MEDICAL & DENTAL ENROLLMENT/CHANGE FORM



Check all that apply:

- New Enrollment* (*new hire, newly eligible*)
- New Enrollment due to loss of other group coverage (*please complete Section 5, Loss of Other Group Insurance on back*)
- Open Enrollment* No Changes (*confirming that current coverage/information is correct*)
- Open Enrollment* Plan Change
- Open Enrollment* Covered Dependent(s) Change: Adding Deleting
- Mid-Year Change due to the following event: Date: _____
 Marriage Birth Divorce Death Other (*Please explain*) _____
- Name Change: List previous name: _____
- Change of Address or Phone Number (*please provide the new information below.*)

* For **New Enrollment** and **Open Enrollment**, you are eligible for the Healthy Benefits program. To qualify, you must complete a Health Status Questionnaire. For more information, contact your employer.

SECTION 1: EMPLOYEE INFORMATION					
EMPLOYEE'S FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YY)	
ADDRESS			CITY	ST	ZIP
HOME PHONE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED			GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
EMPLOYER'S NAME		PERS ELIGIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	PAYCYCLE <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-MONTHLY		DATE OF HIRE
JOB CLASSIFICATION: <input type="checkbox"/> ADMINISTRATIVE/PROFESSIONAL/GENERAL <input type="checkbox"/> ELECTRICAL WORKER <input type="checkbox"/> POLICE/SHERIFF <input type="checkbox"/> MANAGEMENT/SUPERVISORS <input type="checkbox"/> PUBLIC WORKS/LABORER <input type="checkbox"/> FIRE <input type="checkbox"/> HEALTH PROFESSIONALS <input type="checkbox"/> ELECTED OFFICIALS <input type="checkbox"/> EMT			EMPLOYEE'S JOB TITLE/OCCUPATION		

SECTION 2: MEDICAL/DENTAL COVERAGE INFORMATION
<i>Not all coverage options listed below may be offered by your employer. Check with your employer for information regarding available coverage.</i>
<input type="checkbox"/> Medical Plan Name: _____
<input type="checkbox"/> Dental Plan Name: _____

SECTION 3: DEPENDENT INFORMATION							
SPOUSE'S FIRST NAME	MI	LAST		SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL
DOMESTIC PARTNER'S FIRST NAME **	MI	LAST		SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP <input type="checkbox"/> NATURAL <input type="checkbox"/> STEP <input type="checkbox"/> LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP <input type="checkbox"/> NATURAL <input type="checkbox"/> STEP <input type="checkbox"/> LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP <input type="checkbox"/> NATURAL <input type="checkbox"/> STEP <input type="checkbox"/> LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP <input type="checkbox"/> NATURAL <input type="checkbox"/> STEP <input type="checkbox"/> LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL
CHILD'S FIRST NAME	MI	LAST	RELATIONSHIP <input type="checkbox"/> NATURAL <input type="checkbox"/> STEP <input type="checkbox"/> LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL

** Requires completion of Certificate of Domestic Partnership

SECTION 4: OTHER INSURANCE INFORMATION

If you or any family members listed on this application have other insurance, please complete the following:

Coverage 1	NAME OF POLICYHOLDER WITH OTHER COVERAGE	RELATIONSHIP	NAME OF INSURANCE CARRIER
	THIS COVERAGE IS FOR: <input type="checkbox"/> MEDICAL <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> VISION <input type="checkbox"/> DENTAL <input type="checkbox"/> ORTHODONTIA		GROUP/POLICY #
	THIS PLAN COVERS: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN) <input type="checkbox"/> STEPCHILD(REN) <input type="checkbox"/> OTHER: _____		
	NAME OF EMPLOYER		
Coverage 2	NAME OF POLICYHOLDER WITH OTHER COVERAGE	RELATIONSHIP	NAME OF INSURANCE CARRIER
	THIS COVERAGE IS FOR: <input type="checkbox"/> MEDICAL <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> VISION <input type="checkbox"/> DENTAL <input type="checkbox"/> ORTHODONTIA		GROUP/POLICY #
	THIS PLAN COVERS: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN) <input type="checkbox"/> STEPCHILD(REN) <input type="checkbox"/> OTHER: _____		
	NAME OF EMPLOYER		

SECTION 5: MEDICARE INSURANCE INFORMATION

If you or any family members listed on this application have Medicare, please complete the following:

MEMBER'S FIRST NAME	LAST NAME	EFFECTIVE DATE	MEDICARE NUMBER (PLEASE INCLUDE ALPHA PREFIX)
IS MEDICARE COVERAGE: <input type="checkbox"/> PART A <input type="checkbox"/> PART B		REASON FOR MEDICARE ENTITLEMENT: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY	

SECTION 6: LOSS OF OTHER GROUP INSURANCE

If you are applying due to loss of other health coverage, please include a copy of your certificate of coverage and complete the following:

POLICYHOLDER'S FIRST NAME	LAST NAME	RELATIONSHIP	IDENTIFICATION NUMBER
POLICY NUMBER	DATE COVERAGE BEGAN	DATE COVERAGE ENDED	REASON FOR LOSS OF COVERAGE
NAME OF INSURANCE COMPANY/ADDRESS/PHONE NUMBER			
THIS COVERAGE WAS AN:		THIS PLAN COVERED (Check all that apply):	
EMPLOYER PLAN: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	INDIVIDUAL PLAN: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	<input type="checkbox"/> FAMILY AS LISTED ON FRONT <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> SELF ONLY <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD(REN) <input type="checkbox"/> STEPCHILD(REN)	

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment of services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- an insurance carrier or group health plan

Health information requested or disclosed may include, but is not limited to; claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I certify that the dependents listed on this enrollment form meet the definition of eligible dependents as defined by CIS Trust Policies (see your employer for a copy). I understand that if this application contains material misstatements or omissions, CIS or the insurer may deny coverage, modify or cancel and/or take any other legal action available by law.

I wish to make the elections indicated on this form. I authorize deductions from my wages to cover my contribution, if required, toward the cost of coverage. I understand that my deduction amount will change if my coverage or costs change.

Signature: _____

Date: _____