



# Employee Enrollment and Change Form

**EMPLOYEE: PLEASE COMPLETE THIS SECTION**

Coverage Effective Date \_\_\_\_\_ Original Date of Hire \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 Group Name \_\_\_\_\_ Date of Hire \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 Group Number \_\_\_\_\_ Date Transferred From \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 \*Group number should match health plan choice, if selected by employee in section below. Part (P/T) to Full Time (F/T) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 Hours Worked Per Week \_\_\_\_\_  
 Choose one:  Group Health Cooperative  Group Health Options, Inc. If Retired, Date of Retirement \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 Date Processed \_\_\_\_\_ By \_\_\_\_\_

Choose one:  
 Open Enrollment  New Employee  
 Address/Name Change  Add Dependent(s)  
 Remove Coverage  Subscriber \_\_\_\_\_ Dependent(s) \_\_\_\_\_

Transfer to COBRA  
 Start Date \_\_\_\_\_  
 18 months  
 36 months

**EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.**

Employee Name \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.) \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (ZIP) \_\_\_\_\_  
 Resident Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (ZIP) \_\_\_\_\_  
 Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Employee Medicare Claim # \_\_\_\_\_ Former Name of Applicant or Spouse \_\_\_\_\_  
 Date Married \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_  
 Health Plan \_\_\_\_\_ Group Number \_\_\_\_\_

Marital Status:  Single  Married

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE		PLEASE PRINT LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	MALE/ FEMALE	BIRTH DATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE							
			SELF						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						

**DEPENDENT ELIGIBILITY INFORMATION** Please list names of **married dependents**:

1. \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.)

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number**:

1. Spouse Medicare Claim # \_\_\_\_\_ 2. Dependent Name \_\_\_\_\_ 3. Medicare Claim # \_\_\_\_\_

**ADDITIONAL HEALTH BENEFITS INFORMATION**

Other insurance (that is not Group Health Cooperative or Group Health Options, Inc.): \_\_\_\_\_  
 Who is the subscriber under this plan? \_\_\_\_\_  
 What is their social security or policy number with this plan? \_\_\_\_\_ Attach any certificate of creditable coverage letters to the back of this form.