Administered by

SIEBA LTD
SPECIALISTS IN EMPLOYEE BENEFIT ADMINISTRATION

OFFICE USE	DATE RECEIVED

☐ BENEFIT ENROLLMENT FORM

☐ DENTAL

GROUP #	
OFFICE USE ONLY	UNIT #
	EFFECTIVE DATE
	BY

EMPLOYER NAME:

☐ **ADD**
☐ **TERMINATE** ➡ EMPLOYEE enroll for → ☐ SINGLE ☐ EMPLOYEE + ONE ☐ FAMILY
☐ DEPENDENT(S) list below ☐ REASON FOR TERMINATION _____

☐ **CHANGE** ➡ ☐ COVERAGE to → ☐ SINGLE ☐ EMPLOYEE + ONE ☐ FAMILY
→ ☐ COBRA ☐ RETIRED ☐ OTHER _____
☐ ADDRESS ☐ OTHER INFORMATION BELOW

Employee Information

LAST NAME | FIRST | INITIAL | SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX (check) ☐ MALE ☐ FEMALE | DATE OF BIRTH | HIRE DATE | CURRENT MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

EMPLOYEE # | DEPT# | DEPT NAME | HOME PHONE ( )

Dependent Information

LAST NAME (IF DIFFERENT)	FIRST NAME	DATE OF BIRTH month	day	year	RELATIONSHIP spouse	son	daugh	stepson	stepdau	SOCIAL SECURITY NO
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	

HAS FULL TIME STUDENT STATUS BEEN VERIFIED WITH YOUR EMPLOYER?

Other Health Coverage

IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES NAME OF SPOUSE'S EMPLOYER_____

DOES YOUR SPOUSE HAVE OTHER GROUP INSURANCE? ☐ NO ☐ YES - CHECK ALL THAT APPLY BELOW

NAME OF CARRIER_____

MEDICAL COVERAGE	DENTAL COVERAGE	VISION COVERAGE
☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY	☐ SINGLE ☐ FAMILY

ARE YOU COVERED BY MEDICARE? ☐ NO ☐ A ☐ B - EFFECTIVE DATE ____/____/_____

IS YOUR SPOUSE COVERED BY MEDICARE? ☐ NO ☐ A ☐ B - EFFECTIVE DATE_____/_____/_____

Dependent Children Information

IS THERE A COURT ORDER FOR HEALTH COVERAGE RESPONSIBILITY? ☐ NO ☐ YES - ATTACH A COPY

IF THERE ARE STEP CHILDREN, WHO HAS CUSTODY OF THEM? ☐ MOTHER ☐ FATHER ☐ JOINT

IF YOUR SPOUSE DOES NOT HAVE SOLE CUSTODY, ANSWER THE QUESTIONS BELOW.

DOES THE PARENT WITH CUSTODY HAVE OTHER HEALTH COVERAGE FOR THESE CHILDREN? ☐ NO ☐ YES

NAME OF CARRIER_____

☐ MEDICAL COVERAGE ☐ DENTAL COVERAGE ☐ VISION COVERAGE

NAME OF OTHER PARENT_____DATE OF BIRTH_____/_____/_____

All information furnished hereon is true and complete to the best of my knowledge. If a contribution to the above named Plan(s) is required, I authorize the deduction from my earnings.

X _____ DATE_____
SIGNATURE

BENENROL.98