Administered by SIEBA LTD
SPECIALISTS IN EMPLOYEE BENEFIT ADMINISTRATION

OFFICE USE	DATE RECEIVED

BENEFIT ENROLLMENT FORM

☐ **DENTAL**

OFFICE USE ONLY	
GROUP #	
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 (circle) 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