

GROUP NAME _____	POLICY/DIV# _____
PHONE # _____	FORM PREPARED BY _____ DATE: _____

Please refer to your Administration Manual for further instructions on completing this form. New employees and increases in coverage may be subject to eligibility/evidence of insurability requirements. **An enrollment card is required and should be kept on file by you for all contributory and life coverages.** Please consult your group policy or Administration Manual.

EMPLOYEE ADDITIONS

1 Social Security Number	Name (Last, First, Middle Initial)	Birthday Mo/Day/Yr	Sex F/M	State of Employ	Billing Category
Earnings <input type="checkbox"/> wk <input type="checkbox"/> hr <input type="checkbox"/> mo <input type="checkbox"/> yr	hrs/wk if less than 40	Date of Full-Time Employment	Code* <input type="text"/>	Job Title	
Optional Benefits: <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, List: _____			
Note: Some optional benefits require evidence of insurability. Please consult your group policy or Administration Manual.					

2 Social Security Number	Name (Last, First, Middle Initial)	Birthday Mo/Day/Yr	Sex F/M	State of Employ	Billing Category
Earnings <input type="checkbox"/> wk <input type="checkbox"/> hr <input type="checkbox"/> mo <input type="checkbox"/> yr	hrs/wk if less than 40	Date of Full-Time Employment	Code* <input type="text"/>	Job Title	
Optional Benefits: <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, List: _____			
Note: Some optional benefits require evidence of insurability. Please consult your group policy or Administration Manual.					

3 Social Security Number	Name (Last, First, Middle Initial)	Birthday Mo/Day/Yr	Sex F/M	State of Employ	Billing Category
Earnings <input type="checkbox"/> wk <input type="checkbox"/> hr <input type="checkbox"/> mo <input type="checkbox"/> yr	hrs/wk if less than 40	Date of Full-Time Employment	Code* <input type="text"/>	Job Title	
Optional Benefits: <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, List: _____			
Note: Some optional benefits require evidence of insurability. Please consult your group policy or Administration Manual.					

4 Social Security Number	Name (Last, First, Middle Initial)	Birthday Mo/Day/Yr	Sex F/M	State of Employ	Billing Category
Earnings <input type="checkbox"/> wk <input type="checkbox"/> hr <input type="checkbox"/> mo <input type="checkbox"/> yr	hrs/wk if less than 40	Date of Full-Time Employment	Code* <input type="text"/>	Job Title	
Optional Benefits: <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, List: _____			
Note: Some optional benefits require evidence of insurability. Please consult your group policy or Administration Manual.					

5 Social Security Number	Name (Last, First, Middle Initial)	Birthday Mo/Day/Yr	Sex F/M	State of Employ	Billing Category
Earnings <input type="checkbox"/> wk <input type="checkbox"/> hr <input type="checkbox"/> mo <input type="checkbox"/> yr	hrs/wk if less than 40	Date of Full-Time Employment	Code* <input type="text"/>	Job Title	
Optional Benefits: <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, List: _____			
Note: Some optional benefits require evidence of insurability. Please consult your group policy or Administration Manual.					

*FOR INSURANCE COMPANY USE ONLY

FAX OPTION: To ensure **prompt processing** of member changes, please FAX this form toll free to 1-800-378-2403. Changes shown here will be reflected on a subsequent billing statement.

PLEASE ENTER CHANGES AND TERMINATIONS ON PAGE TWO.

