



**EMPLOYEE: PLEASE COMPLETE THIS SECTION**

Coverage Effective Date \_\_\_\_\_

Group Name \_\_\_\_\_

Group Number \_\_\_\_\_

*\*Group number should match health plan choice, if selected by employee in section below.*

**Choose one:**  Group Health Cooperative  Group Health Options, Inc.

Original Date of Hire \_\_\_\_\_

Date of Rehire \_\_\_\_\_

Date Transferred From \_\_\_\_\_

Part (P/T) to Full Time (F/T) \_\_\_\_\_

Hours Worked Per Week \_\_\_\_\_

If Retired, Date of Retirement \_\_\_\_\_

**Choose one:**

Open Enrollment  New Employee

Address/Name Change  Add Dependent(s)

Remove Coverage  Subscriber  Dependent(s)

Date Processed \_\_\_\_\_ By \_\_\_\_\_

**Transfer to COBRA**  
Start Date \_\_\_\_\_

18 months

36 months

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

Employee Name \_\_\_\_\_

(Last Name)

(First Name)

(M.I.)

Marital Status:  Single  Married

Date Married \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Resident Address \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Work Phone (\_\_\_\_) \_\_\_\_\_

Employee Medicare Claim # \_\_\_\_\_

Former Name of Applicant or Spouse \_\_\_\_\_

**Health Plan Choice**

*If more than one health plan is offered, please write in your choice, including the group number.*

\*Health Plan \_\_\_\_\_

Group Number \_\_\_\_\_

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	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE							
			SELF						
			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.

(Signature of Employee)

(Date Signed)

Please retain a copy for your records