

Effective/
 Change Date:

- New Enrollment
 Rehire or Reinstatement
 Add/Drop Dependents

- Drop Coverage
 Name Change
 Open Enrollment

- Beneficiary Change
 Address Change

EMPLOYEE INFORMATION			
Employer Name:		Location:	Group Number: S24
Name (Last, First, Middle):		Date of Birth: Mo / Day / Year	Social Security Number: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address: Street		City	State Zip
Occupation:	<input checked="" type="checkbox"/> Hourly <input type="checkbox"/> Salaried	Earnings \$ NA <input type="checkbox"/> Hr <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr	Retirement Date:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Phone Number:	Email:	

COVERAGE INFORMATION		
Coverage Elections (Must be completed)		
	Medical	
	Yes	No
Employee	<input type="checkbox"/>	<input type="checkbox"/>
Spouse*	<input type="checkbox"/>	<input type="checkbox"/>

Preferred Provider Organization Keenan EB TPA with Blue Shield	Medical Plan Option RCCD Medical PPO Plan
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List all dependents to be covered including spouse, if applicable:

Full Name	Relationship	Gender	Date of Birth:	Social Security Number:
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	____-____-____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	____-____-____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	____-____-____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	____-____-____
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	___/___/___	____-____-____

I hereby apply for coverage to which I am entitled to or to which I may become entitled under the terms of the employee benefit plan issued to my employer and/or sponsored by my employer. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage.

Employee Signature Date

WAIVER OF GROUP COVERAGE	
<input type="checkbox"/> I do not want Medical coverage:	<input type="checkbox"/> For myself <input type="checkbox"/> For my dependents
<p>I hereby certify that I have been offered the opportunity to become covered under the plan(s) sponsored by my employer and I have decided not to take advantage of this offer for the coverage listed above. I understand that enrollment into the plan(s) at a later date will be subject to the special enrollment/open enrollment provisions of the plan(s) for health coverages and evidence of insurability for all other coverage(s). I desire to enroll for benefits and hereby authorize my employer to use electronic means for purposes of my enrollment in the benefits plans that I have elected.</p>	
_____	_____
Employee Signature	Date