Group Health Plan Enrollment Application

1. Employee Information

First Name

Last Name

Date of Birth

Gender

Select

Address

City

State

ZIP Code

Phone Number

Email Address

Employer Name

Employee ID

2. Coverage Selection

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

3. Dependent Information

Name
Relationship
Date of Birth
Gender

Select

Select

Select

4. Other Health Coverage

Are you or any dependents covered by another health plan?

☐ Yes ☐ No

If Yes, provide carrier name and policy number:

5. Authorization and Signature

I hereby apply for enrollment for myself and listed dependents and authorize payroll deductions for my share of the costs, if any.

Employee Signature

Date