ENROLLMENT / CHANGE OF STATUS FORM

Please Print Using Black Ink

HR ONLY:
Employee #:_____

Dept/Div. #:_____

Eff. Date: 07/01/2019

SECTION A: QUALIFYING EVENT (Member Please Check One)

☐ New Hire / Open Enrollment
☐ Add / Delete Dependents: (Indicate Date of Qualifying Event) Complete Section C
Marriage: _____ Birth: _____
Divorce: _____ Adoption: _____
Other: _____ Name Change: _____
☐ Address Change
☐ Reason for Termination? _____
☐ Decline Coverage (Complete Sections A, B, D, E)

Administered By:
AmeriBen
PO Box 7186
BOISE, ID 83707
1-866-365-9198
FAX: 602-914-9239

☐Medical Plan A
☐Medical Plan B
☐Medical HDHP
☐Dental

Coverage Selected:
◯Employee ◯Employee & Spouse
◯Employee & Child ◯Employee & Family

SECTION B: MEMBERSHIP INFORMATION

Social Security Number ☐☐☐☐☐☐☐☐☐

Single ☐ Married☐ Divorced☐

Date of Birth: ____ /____ /____

Gender: Male ☐ Female ☐

Employer Position / Title Date of Hire

Last Name First M.I.

Home Address (Mailing) City State Zip Code

SECTION C: DEPENDENT INFORMATION

Add	Change	Delete	Last Name (if different), First, M.I.	Social Security Number	Relationship to Member	Gender	Date of Birth
			(Spouse)			M \ F	
			(Child)			M \ F	
			(Child)			M \ F	
			(Child)			M \ F	
			(Child)			M \ F	

SECTION D: DUAL / OTHER COVERAGE

Is there any other Group Insurance for your family members? ☐Yes ☐No

If yes, Name of Policyholder _____ Policyholder's Date of Birth: _____

Please list dependents covered by this policy: _____

Name of Insurance Company / TPA: _____ Address: _____

Plan / Policy Number: _____ Phone: _____

Name of Employer: _____

SECTION E: WAIVER OF COVERAGE

After a complete explanation of the health plan, and after careful consideration, I am waiving ALL benefit coverage for: (*Check all that apply*)
◯ Employee ◯ Spouse ◯ Children

Reason: _____

If you or your dependents fail to elect or refuse enrollment and decide to enroll for coverage under this plan at a later date, benefits may be deferred for a specified period of time to be determined by your employer. (Schedule D must be completed)

DISCLAIMER INFORMATION: I represent that all answers given are full, complete and true to the best of my knowledge, information and belief.

AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my employer or AmeriBen all information on my behalf including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be covered. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original.

AUTHORIZATION FOR PAYROLL DEDUCTION: I hereby authorize my Employer to deduct any health insurance premium that may be due from my paycheck.

Employee Signature: **Date:**

FOR YABC USE ONLY – DO NOT WRITE BELOW THIS LINE

DATE OF HIRE:	**EFFECTIVE DATE:**
Employer / Administrator Signature:	**DATE:**

Rev: 4/2014