



EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage Effective Date _____

Group Name _____

Group Number _____

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

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

Choose one: Open Enrollment New Employee
 Address/Name Change Add Dependent(s)
 Remove Coverage Dependent(s)
 Date Processed _____ By _____

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 ____/____/____

Transfer to COBRA
 Start Date ____/____/____
 18 months
 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee Name (Last Name) _____ (M.I.) _____ (First Name) _____

Mailing Address _____ (City) _____ (State) _____ (Zip) _____

Resident Address _____ (City) _____ (State) _____ (Zip) _____

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 _____

Marital Status: Single Married Divorced Widowed Other _____

Date Married ____/____/____

Home Phone () _____

Work Phone () _____

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) _____ (M.I.) _____ (First Name) _____ (Last Name) _____ (M.I.) _____ (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)