

This form can be used as an initial enrollment or to report a change in information. Please complete all information by printing clearly and firmly or by typing. If additional space is needed, please attach a statement with the appropriate information. Please check the applicable boxes below.

I. GROUP INFORMATION

New Enrollment Waiver Change Transfer from Location # _____ to Loc # _____ Terminate (check reason below) COBRA
 LOCATION NAME LOCATION NUMBER PHONE NUMBER (including area code)

LOCATION ADDRESS

II. EMPLOYEE INFORMATION ACTIVE PRIEST RETIRED PRIEST RELIGIOUS SEMINARIAN/ OTHER LAYTY CCS CCS DATE OF BIRTH _____ EFFECTIVE DATE: _____

DATE OF HIRE DATE FULL TIME OCCUPATION ANNUAL SALARY HOURS WORKED PER WEEK MARITAL STATUS
 LAST NAME FIRST NAME MIDDLE INITIAL SOC. SEC. NO. GENDER (M/F)
 STREET ADDRESS CITY STATE ZIP HOME PHONE (Including Area Code)

III. COVERAGE ELECTION Complete dependent information section if coverage elected for spouse and/or children

DEPENDENTS ELECTING COVERAGE MUST ENROLL IN THE SAME MEDICAL, VISION OR DENTAL PLANS AS THE EMPLOYEE.

COVERAGE	EMPLOYEE	SPOUSE	CHILD(REN)	WAVE	COVERAGE	EMPLOYEE	SPOUSE	CHILD(REN)	WAVE
United Healthcare Choice Plus	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Delta Dental AZ	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
United Healthcare Yuma PPO	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Employers Dental Service	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
SightCare Vision	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	EDS Dental Facility	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

IV. DEPENDENT INFORMATION (Required if dependent coverage is to be added or changed)

LAST NAME (if different), FIRST NAME - MIDDLE INITIAL	SOB. SEC. NO.	DATE OF BIRTH	MEDICAL (ADD/TERM)	DENTAL (ADD/TERM)	VISION (ADD/TERM)	STUDENT / DISABLED	DEPENDENT CERTIF. ATTACHED
SPOUSE							
DEPENDENT #1						YES <input type="checkbox"/> NO <input type="checkbox"/>	
DEPENDENT #2						YES <input type="checkbox"/> NO <input type="checkbox"/>	
DEPENDENT #3						YES <input type="checkbox"/> NO <input type="checkbox"/>	
DEPENDENT #4						YES <input type="checkbox"/> NO <input type="checkbox"/>	

You will automatically be enrolled in the Basic Life/AD&D insurance plan following your initial waiting period. You must complete a beneficiary designation form for the Basic Life/AD&D plan. You will also be automatically enrolled in the Long Term Disability insurance plan, following two (2) years of continuous employment.

Do you, or any of your family covered under your medical, vision and/or dental insurance plan, have other group medical or dental insurance, HMO, or Medicare coverage?
 No - Please, Sign/Authorize on line below Yes - Please, complete the information below.
 Insurance Company's Name _____ Insurance Company's Phone No. _____ Medicare No. _____
 Policy Holder's Name _____ Policy Holder's SSN _____ Effective Date _____

Covered Dependent's Name(s): _____

V. WAIVER (Signature is required if any benefit is waived)

The current benefits have been explained to me thoroughly. I DO NOT wish to enroll in the following coverage(s):
 EMPLOYEE MEDICAL DENTAL VISION
 EMPLOYEE AND/OR DEPENDENT MEDICAL DENTAL VISION
 Is the coverage being waived due to coverage by another health plan? Yes No I understand that by waiving the coverage above, I will not be entitled to any benefits provided by the plan.
 SIGNATURE (To Waive Benefits): _____ DATE: _____

VI. RELEASE

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document, that the above information in complete and accurate, and all claims submitted will be for individuals who are eligible members of the health plan. I hereby authorize the Plan Sponsor to deduct from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my health costs when in excess of the amounts payable under the plan. I also authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give the health plan, or emotional disorders, A.I.D.S., or A.R.C. of me or any of my dependents applying for coverage or of any claim for benefits. I also authorize the health plan to disclose all such health or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits. If my coverage is under a master policy held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for the purpose of administering my coverage, utilization review or financial audit. This authorization is effective immediately and shall remain in effect for use in connection with any claim for benefits for as long as any health coverage may be in effect. A photocopy of this authorization is as valid as the original. The information provided above is true and correct to the best of my knowledge. I have read, understood, and agree to all sections and the terms of this enrollment form.

EMPLOYEE SIGNATURE (Required): _____ **DATE:** _____

TO BE COMPLETED BY LOCATION ADMINISTRATOR ONLY

VII. REASON FOR THE CANCELLATION/CHANGE:

EMPLOYEE COVERAGE
 Lay-Off Last day worked _____
 Retirement Deceased: Date _____
 Resignation: Date Submitted _____ Reduction of work hours: Date _____
 Disability: Date _____ Increase in work hours: Date _____
DEPENDENT COVERAGE:
 Death of covered dependent _____
 No longer an eligible dependent _____
 NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT): _____ SIGNATURE: _____ DATE: _____
 Date of divorce/legal separation _____
 Termination of dependent's health coverage _____
 Eligible for Medicare _____

VIII. EMPLOYEE STATUS

TYPE OF CHANGE
 New Hire Re-Hire Employee Status Change
 Regular Full-Time (30 Hours or More) Hours Per Week: _____
 Regular Part-Time (29 hours or less) Hours Per Week: _____
 Temporary (Short Term) Hours Per Week: _____
 On Call (As Needed)

IX. STATUS CHANGE

Location Change (Transfer) From: _____ To: _____
 Position Change From: _____ To: _____
 Leave of Absence From: _____ To: _____
 Other From: _____ To: _____

X. SALARY ESTABLISHMENT/CHANGE

TYPE OF CHANGE
 New Hire Merit Increase Promotion Other
 Current Pay Rate: \$ _____ Per Hour Per Year \$ _____
 New Pay Rate: \$ _____ Per Hour Per Year \$ _____
 Exempt (Salaried) Non-Exempt (Hourly)

XI. TERMINATION OF EMPLOYMENT

Last Working Day: ____/____/____ Eligible For Retiree? Yes No (If No, list reason)
***Please Complete A Work History Form For Pension**

Select ONE Reason For Separation:

VOLUNTARY:
 Dissatisfied w/Job or Company Retirement School No Call/No Show Better Job/Pay/Benefits/Hours
 Medical-Self or Family Relocating Family Issues Other
INVOLUNTARY:
 Poor Performance Gross Misconduct Attendance/Tardiness Unqualified for Job
 Violation of Company Policy/Procedure Unprofessional Conduct Other