Employee Enrollment /Change of Status Notification

☐ New Enrollee ☐Termination ☐Status Change		Enrollment Type ☐Medical ☐Pharmacy ☐Dental		
Group Name		Group Number		Coverage Effective Date
Social Security Number	Cardholder Name (First, Middle Initial, Last)		Gender ☐Male ☐Female	Date of Birth
Address ☐check if address update			State	Zip Code
Phone Number		Current Health Insurance Program ☐ (EHIM Fill In Choice) ☐ (EHIM Fill In Choice) ☐ (Fill In)		Hire Date
Company Division (if applicable)	Location Code (if applicable)		Department Code (if applicable)	

DEPENDENTS TO BE INSURED/TERMINATED

Add/Term.	Relationship	SSN	Name	Date of Birth	Other Coverage	If Yes, Please Carrier & Policy #	Gender
	Spouse				☐Y ☐N		☐M ☐F
	Child				☐Y ☐N		☐M ☐F
	Child				☐Y ☐N		☐M ☐F
	Child				☐Y ☐N		☐M ☐F
	Child				☐Y ☐N		☐M ☐F

TERMINATION INFORMATION

Action	Contract Number	Social Security Number	Cardholder Name	Term Date	COBRA Offered
Terminate					☐Y ☐N

☐ Terminate ENTIRE CONTRACT ☐ Terminate SPOUSE only ☐ Terminate DEPENDENTS only (list Dependents to terminate above)

COBRA INFORMATION

☐ COBRA has been elected for CARDHOLDER only.
☐ COBRA has been elected for CARDHOLDER & SPOUSE.
☐ COBRA has been elected for CARDHOLDER & FAMILY.
☐ COBRA has been elected for SPOUSE only.
☐ COBRA has been elected for DEPENDENTS only.
☐ Active COBRA Policy is being terminated.

Social Security Number	Name	COBRA Effective Date / COBRA Termination Date

I acknowledge that EHIM requires me to disclose specific identifying information when completing this application. I and my covered dependents agree to permit EHIM to release protected health information (PHI) for the purposes of administering this Plan as directed by the Plan Administrator and for other purposes necessary for EHIM to fulfill its contractual and statutory obligations.

Authorized Signature _____ Date _____

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