

EMPLOYER COMPLETES SECTION BELOW:										
EMPLOYER NAME: White Memorial Medical Center								GROUP NO.: 024		
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Name/Address Change		<input type="checkbox"/> Decline Coverage		<input type="checkbox"/> Reinstatement <input type="checkbox"/> Layoff		<input type="checkbox"/> Benefit Change <input type="checkbox"/> Termination		<input type="checkbox"/> PCP Change		Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Per Diem
Hire/Reinstatement Date:			Termination/Layoff Date:			Coverage Cancellation Date:				
<input type="checkbox"/> No Waiting Period - Reason:								<input type="checkbox"/> Transfer From:		
Medical Effective Date:			Dental Effective Date:			Comments:				
Monthly Contribution: \$			Monthly Contribution: \$							
Authorized Signature:								Date:		
EMPLOYEE INFORMATION: (Please write legibly)										
Employee Last Name			First		Initial	Jr/Sr/#	Home Phone			
Mailing Address					City		State	Zip		
DEPENDENT INFORMATION: (Please write legibly)										
	A(dd) D(rop)	Last Name	First	MI	Jr/Sr	Birthdate	Sex M F	Coverage Med Dtl	Certificate # or SSN	Primary Care Physician
Employee										
Spouse										
Children 1.										
2.										
3.										
4.										
5.										
Are you or your dependents covered under any other group plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide the following information:										
Name of Insured					Insurance/Group Plan Name					
Address of Insurance Carrier									Policy No.	
Coverage type: <input type="checkbox"/> Single <input type="checkbox"/> Family			Names of covered individuals:							
ACCEPTANCE:										
I hereby apply for benefits provided under my employer's group benefit plan. I authorize payroll deductions, if required, for the cost of coverage I have selected. I certify that the information given on this enrollment form is complete and correct, and I understand that if the information is not complete and correct, this coverage could be retroactively terminated. I have received a copy of the Summary Plan Description for this healthcare coverage, and I have read and understand the "Eligibility & Effective Dates," "Health Care Management Program," and "Preferred Provider Selection" guidelines included in the booklet.										
Employee's Signature						Date				