CORE BENEFITS INC.
Quality, Compliance & Service

ENROLLMENT/CHANGE FORM

Employer	Plan Number	Social Security #

Name (First, MI, Last)	Date of Birth	Sex (M/F)

Street Address	City	State	Zip

Marital Status ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**

EMPLOYER SECTION

☐Open Enrollment (original eff date _____) ☐Late Enrollment
☐Initial Enrollment (date employed full-time _____) ☐Change of Information/Coverage
☐Rehire (date re-employed full-time _____) ☐Termination/Reduction of hours (date _____)
☐Special Enrollment - please select the reason for special enrollment and the date of the event:
☐Marriage ☐Newborn ☐Adoption/Child placed for adoption ☐Loss of other coverage
Date of event: _____ Attach supporting documentation (i.e. birth or marriage certificate, etc.)

PARTICIPANT INFORMATION

LIST THOSE DEPENDENTS TO BE COVERED

Relationship	Name (First, MI, Last)	Sex (M/F)	DOB	Medical	Dental	Vision
Employee				☐	☐	☐
Spouse				☐	☐	☐
Child				☐	☐	☐
Child				☐	☐	☐
Child				☐	☐	☐
Child				☐	☐	☐
Child				☐	☐	☐

OTHER COVERAGE

Is other coverage provided for any family members? ☐Yes ☐No
If so, please provide the names of individuals covered, the type of coverage provided and the company name:

BENEFICIARY INFORMATION

Name	Relationship
Address	
Contingent Beneficiary	Relationship
Address	

I declare that the above information is correct and true. I authorize payroll deduction on a pre-tax basis from my earnings for any contribution I am required to make.

_____ _____
Signature Date

DECLINATION OF COVERAGE

Note: You must complete this section if you decline coverage for yourself (if single) or family coverage (if married).

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your coverage ends. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days of the event.

_____ _____
Signature Date