Name Date

Practice Insurance Enrollment Form

On the first day of your new job, your employer asks you to complete an insurance enrollment form. You are going to have traditional health and dental insurance coverage, not only for yourself but also for your spouse and three children. You work for Office Furniture Warehouse as an assistant manager, and the company's insurance group number is 4532-3. You also are going to enroll in the life insurance coverage. You don't want any other type of insurance at this time.

Employee Information

Full Legal Name (last, first, middle initial)

Street Address

PO BOX (if any)

City State ZIP Code

Social Security Number

Date of Birth

Phone Number Gender

Employment Information

Employer Name

Insurance Group Number

Date of Employment

Position

Reason Why You Are Enrolling

continued on next page

Name Date

Insurance Coverage

Health

- ❍ Single
- ❍ Family

Type of Plan (choose only one type)

- ❍ Traditional (80/20 Plan)
- ❍ PPO (Preferred Provider Plan)
- ❍ Fill in circle, and initial line if you don't enroll. ________

Alternate Benefit Programs

Dental

- ❍ Single
- ❍ Family

Long-Term Disability

- ❍ Self
- ❍ Self and Spouse
- ❍ Fill in circle, and initial line if you don't enroll. ________

Long-Term Care

- ❍ Self
- ❍ Self and Spouse
- ❍ Fill in circle, and initial line if you don't enroll. ________

Life

- ❍ Self
- ❍ Self and Spouse
- ❍ Fill in circle, and initial line if you don't enroll. ________

continued on next page

Name .... Date

Dependent Information

Is your spouse or one of your dependent children disabled?

- ❍ Yes
- ❍ No

If so, please state the dependent's name and the nature of the disability.

____

____

Fill out the following information for your spouse and any dependents (if applicable):

____

First Name Middle Initial Last Name

Relationship

- ❍ Spouse
- ❍ Child
- ❍ Other ______________

Gender

- ❍ Male
- ❍ Female

____

Date of Birth Social Security Number

continued on next page

Name .... Date

First Name Middle Initial Last Name

Relationship

- ❍ Spouse
- ❍ Child
- ❍ Other ____________________

Gender

- ❍ Male
- ❍ Female

Date of Birth Social Security Number

First Name Middle Initial Last Name

Relationship

- ❍ Spouse
- ❍ Child
- ❍ Other ____________________

Gender

- ❍ Male
- ❍ Female

Date of Birth Social Security Number

All of the information I have provided is true, to the best of my knowledge.

Signature Date