Enrollment Form

boon·chapman

Employer's Name: _____ Employer's #: _____

Participant's Name: _____ Reason for filling out form: _____
(Last, First, Middle Initial)

Instructions

1. Please print or type.
2. If your employer's name and number are not pre-printed at the top, please fill in.
3. Fill in your name at the top.
4. Complete all information in Sections I, II, and III.
5. When you've finished, be sure to sign and date the form, Section IV.

For Office Use Only
Effective Date:
_____

I. EMPLOYEE INFORMATION

Date of Birth: _____ Gender: _____ Social Security Number: _____ Hire Date: _____

Address: _____
Street *City* *State* *Zip*

Email: _____ Phone #: _____ Job Title: _____

II. COVERAGE INFORMATION

Marital Status: ☐ Single ☐ Married Medical Plan Election: ☐ Yes ☐ No Dental Plan Election: ☐ Yes ☐ No

I want medical benefits provided for:

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

I want dental benefits provider for:

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

I want to provide coverage for the following dependents:

Medical	Dental							
☐	☐	Spouse:	_____	SSN:	_____	DOB:	_____	Sex: _____
☐	☐	Child:	_____	SSN:	_____	DOB:	_____	Sex: _____
☐	☐	Child:	_____	SSN:	_____	DOB:	_____	Sex: _____
☐	☐	Child:	_____	SSN:	_____	DOB:	_____	Sex: _____

If you have more than 3 dependent children, indicate the total number here: _____, and list their full names, sexes, dates of birth, and medical/dental election at the end of this form.

III. OTHER INSURANCE INFORMATION

1. Are you or any of your family members covered by other insurance? ☐ Yes ☐ No
   If "YES", please complete the information below. If "NO", please skip to section IV
2. If you answered "Yes" to question 1, please complete the following:
   a) Other Insurance Policy Holder's Name: _____
   b) Other Insurance Policy Holder's ID: _____
   c) Other Insurance Policy Holder's Date of Birth: _____
   d) Other Insurance Policy Type (check all that apply): ☐ Medical ☐ Dental ☐ Vision
   e) Other Insurance Policy Holder's Effective Date of Coverage: _____
   f) Other Insurance Carrier's Name: _____
   g) Other Insurance Carrier's Phone #: _____

IV. AUTHORIZATION

Your signature completes the enrollment process. It activates the benefits to be provided. It also authorizes the appropriate payroll deduction form your earnings to provide the coverage requested.

Participant's Signature: _____ Date: _____