



P.O. Box 2365
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Franklin West Supervisory Union
 NEW ENROLLMENT CHANGE OF STATUS

EMPLOYEE – MUST COMPLETE ALL INFORMATION IN SECTIONS 1 THROUGH 7

SECTION 1 – EMPLOYEE PARTICIPANT INFORMATION

Social Security Number	Last Name <input type="checkbox"/> check if new	First Name	MI	Date of Birth
Home Mailing Address <input type="checkbox"/> check if new	City		State	Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone	Work Phone	Current Marital Status <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	

SECTION 2 – DEPENDENT INFORMATION

	Check One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	Enter "Dep" Relationship Code
Spouse or Partner	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep-1	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep-2	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep-3	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep-4	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep-5	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			

DEP Relationship Codes:

C-Child (Birth/Adoption) **L**-Legal Guardianship* **CO**-Court Order Coverage* **SP**-Spouse
F-Full Time Student 19+ **D**-Disabled Child (attach Physician Statement) **DP**-Domestic Partner**
S-Stepchild***

*= Attach Court Order **= Attach Statement of Domestic Partnership
 *** = Who is legally responsible for stepchild(s) medical bills? _____

Full Time Student 19+ (Please Provide):

Dependent Name _____
 Name of School: _____
 Expected Graduation Date: _____
 Dependent Name _____
 Name of School: _____
 Expected Graduation Date: _____

SECTION 3 – ENROLLMENT CHOICES

Elect Dental Coverage: Single 2 Person Family

Waive Coverage: Dental (Check Box if declining coverage and complete a "Waiver of Coverage" form)

SECTION 4 - SPOUSE EMPLOYER INFORMATION

Is Spouse Employed? Yes No If yes, provide Name & Address of Employer: _____
 Does Spouse's Employer offer medical and/or dental coverage? Medical: Yes No Dental: Yes No

SECTION 5 - OTHER COVERAGE

Do you, your spouse or dependent(s) maintain other health or dental coverage? YES NO If Yes, complete below and provide a copy of the Plan's ID card.

Policyholder Name	Policy Number	Group Number	Insurance Company Name & Address	Effective Date: _____ <input type="checkbox"/> Single <input type="checkbox"/> 2P <input type="checkbox"/> Family
Policyholder Name	Policy Number	Group Number	Insurance Company Name & Address	Effective Date: _____ <input type="checkbox"/> Single <input type="checkbox"/> 2P <input type="checkbox"/> Family

Are you, your spouse or any dependents listed in Section 2 enrolled in Medicare? Yes No
If yes, attach a copy of Medicare card(s). Actively Working Retired Under Age 65 ESRD (End Stage Renal Disease)

SECTION 6: HIPAA COMPLIANCE

Will this plan replace existing dental insurance coverage? YES NO **If yes, attach a certificate of prior dental insurance coverage.** Your Prior insurer will give you this form.

SECTION 7: SUBSCRIBER SIGNATURE

I certify that the statements on this enrollment form and all information furnished by me are true and complete to the best of my knowledge. I and any enrolled dependants agree to permit any healthcare provider to release/disclose any information (including Protected Health Information) acquired in connection with any past or future care or treatment to Comprehensive Benefits Administrator, Inc. \ Employee Benefit Plan Administration, Inc., or its designated agent for purposes of administering healthcare coverage.

Subscriber's Signature	Date
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******EMPLOYER USE ONLY – EMPLOYER CHECK AND COMPLETE APPROPRIATE AREAS BELOW******

COVERAGE EFFECTIVE DATES:	Medical Effective Date:	Dental Effective Date:	Vision Effective Date:	STD Effective Date:
EMPLOYEE STATUS: Group: 50683	Date of Hire	or Full Time Status	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> HIPAA Qualifying Event (describe event): _____	
REASON FOR STATUS CHANGE:	Effective Date:	<input type="checkbox"/> Marriage <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Loss of Coverage (Certificate of Creditable Coverage Required) <input type="checkbox"/> Transfer <input type="checkbox"/> HIPAA Qualifying Event (describe event): _____		
CANCEL COVERAGE:	Effective Date:	<input type="checkbox"/> All REASON: <input type="checkbox"/> COBRA <input type="checkbox"/> Divorce <input type="checkbox"/> Retired <input type="checkbox"/> Death <input type="checkbox"/> Left Employment <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent over Age <input type="checkbox"/> Other Insurance <input type="checkbox"/> Dependent(s) list in Section 2 <input type="checkbox"/> Other describe): _____		