# INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

**Employer Use Only**

Group Name

Group ID | Employee Code

Effective Date Requested ___/___/___

Network | Division

Employer's Signature & Date

## SECTION 1

Your Last Name | First | M.I.

Address

City | State | Zip Code

Your SS No. _____

☐ Single ☐ Married ☐ Divorced

In case of change due to Marriage: In case of change due to Divorce

Date of Marriage ___/___/___ Date of Divorce ___/___/___

Phone No. (___) _____ (___) _____

Employment Status: Active: ☐ Full-time ☐ Part-time ☐ Retired ☐ COBRA

Date of Employment: ___/___/___ Date of Retirement: ___/___/___

## SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)
☐ Change Coverage to: (check new coverage)
☐ Cancel Coverage: (check those that apply)
☐ Add or Delete Dependent: (complete Section 4)
☐ Change Enrollee's Information: (complete Section 1 with new information)

REASON: _____

| Type | Option | Single | Husband/Wife or Parent/Child | Parent/Children or Family | Complement to Medicare |
|---|---|---|---|---|---|
| Medical | | ☐ | ☐ | ☐ | ☐ |
| PPO | | ☐ | ☐ | ☐ | ☐ |
| POS | | ☐ | ☐ | ☐ | ☐ |
| EPO | | ☐ | ☐ | ☐ | ☐ |
| Dental | | ☐ | ☐ | ☐ | ☐ |
| Vision | | ☐ | ☐ | ☐ | ☐ |
| Rx | | ☐ | ☐ | ☐ | ☐ |
| Life | | ☐ | ☐ | ☐ | ☐ |

Date of change: ___/___/___

## SECTION 3

**OTHER COVERAGE?** (Inaccurate information may result in claim delay or denial.)
Is there coverage under any other group health plan available to you or any member of your family?
☐ No ☐ Yes, Effective Date ___/___/___

If Yes; Policyholder Name & ID/SS No.

Relationship ☐ Self ☐ Spouse ☐ Child

Birthdate ___/___/___

Insurance Co. Name & Address

Policy #

**Plan Type:** ☐ Single ☐ Husband/Wife or Parent/Child ☐ Parent/Children or Family

**Coverage Type:** ☐ Medical ☐ Drug ☐ Dental ☐ Vision

## SECTION 4

**LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS**

Copy of medical card required

| ADD | DELETE | RELATIONSHIP | DEPENDENT NAME Last | First | M.I. | Birth Date (mo/day/yr) | Full-time Student | ID/SS No. | Enrolled under Medicare A & B Effective Date |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | **Self** ☐ M ☐ F | | | | / / | | - - | / / |
| ☐ | ☐ | ☐ Husband ☐ Wife | | | | / / | | - - | / / |
| ☐ | ☐ | ☐ Son ☐ Daughter | | | | / / | ☐ Yes ☐ No | - - | / / |
| ☐ | ☐ | ☐ Son ☐ Daughter | | | | / / | ☐ Yes ☐ No | - - | / / |
| ☐ | ☐ | ☐ Son ☐ Daughter | | | | / / | ☐ Yes ☐ No | - - | / / |

## SECT 5

Do your dependents reside in your home?
☐ Yes ☐ No If No, give address:

Do you have a disabled dependent beyond initial limiting age?
☐ Yes ☐ No List Name(s):

Enrolled under Medicare? ☐ Yes ☐ No

Full-time students exceeding initial limiting age: (Must provide each semester to show Full-time student status)
List Names | School Name and Address | Expected Graduation

## SECT 6

*The Beneficiary selection applies to Life/Life with AD&D Insurance available through your Employer, if any. Selection(s) of Beneficiary(ies) is(are) not valid unless signed, dated and delivered to the Employer during your lifetime.*

| Primary – Full Name | Address | SS# | Relationship | % of Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |
| Secondary – Full Name | | | | |
| | | | | |
| | | | | |

Applicant's Signature _____ Date ___/___/___

***For ALL coverage enrollments a Certificate of Creditable Coverage MUST be provided.***