

General Information

This form is required for all eligible employees and dependents who are not enrolling with US Health and Life at the time of initial enrollment and/or the group's open enrollment period.

Group (Employer) Name _____

Date of Hire _____

First Name _____ MI _____ Last _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Male Female

Daytime Phone Number _____ Email Address _____

Life Insurance Beneficiary Name _____ Relationship _____

I decline to enroll for Medical (check all that apply): myself spouse children

Dependent Information

Coverage Selection: Dental Yes No Dependent Life Yes No

Please complete the following for each enrolling individual for dependent life and/or dental if elected by group.

First Name	MI	Last Name	Relationship	Date of Birth	Sex	Social Security No.
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Waiver

I waive the right to enroll with US Health and Life as offered to me by my employer for the following reason (please check one):

I have other coverage through my spouse I have other coverage through Medicare

I have individual coverage I have no other coverage but choose not to enroll in my employer's plan

Other (explain) _____

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption.

Employee Signature _____ Date _____

For Office Use Only		
EFF DATE _____	MED _____	CLASS _____
DIVISION # _____	DEN _____	LIFE _____