EMPLOYEE ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY	
ENTERED	
ID CARDS	
HIPAA	

A. EMPLOYEE INFORMATION (1-13)

1. COMPANY NAME:

L.J. GONZER ASSOCIATES, INC.

2. EMPLOYEE'S (LAST NAME)	(FIRST NAME)	(MIDDLE INITIAL)

3. ADDRESS	APT #	CITY

STATE	ZIP	4. WORK PHONE	5. HOME PHONE
		( )	( )

6. SOCIAL SECURITY NUMBER	7. DATE OF BIRTH	8. SEX
		_____ MALE _____ FEMALE

9. PLAN

☐ PLAN A- PLATINUM PPO ☐ PLAN C- BRONZE PPO ☐ PLAN E- COPPER PLAN ☐ Waive Medical Coverage

☐ PLAN B- SILVER EPO ☐ PLAN D- MEC PLAN

10. FAMILY STATUS

_____ EMPLOYEE ONLY _____ EMPLOYEE & SPOUSE _____ EMPLOYEE & CHILD(REN) _____ FULL FAMILY

11. PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED:

NAME	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH
	SPOUSE/DOMESTIC PARTNER		
	CHILD		
	CHILD		
	CHILD		
	CHILD		
	CHILD		

12. DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH COVERAGE: ☐ YES ☐ NO

IF YES, NAME OF THE CARRIER/PLAN	EFFECTIVE DATE:

13. REQUEST FOR GROUP INSURANCE

I hereby apply for insurance to which I am entitled or to which I may become entitled under terms of the group policy or policies issued by my employer. I authorize the deduction if any, from my earnings or any contribution I am required to make toward the cost of this insurance. I understand that if I do not enroll when first eligible that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability.

SIGNATURE _____ DATE SIGNED _____

B: TO BE COMPLETED BY EMPLOYER (14-19)

14. DATE OF HIRE	15. DEPARTMENT # / LOCATION

16. DATE ELIGIBLE FOR COVERAGE	17. COBRA (WHEN APPLICABLE)	
	DATE OF TERMINATION	☐ 18 MONTHS ☐ 36 MONTHS ☐ OTHER

18. TYPE OF TRANSACTION (CHECK ONE)

ENROLLMENT	**TERMINATION** EFFECTIVE DATE: _____	**CHANGE** EFFECTIVE DATE: _____
_____ NEW ENROLLMENT	_____ TERMINATING EMPLOYMENT	_____ ADD DEPENDENT
_____ REHIRE	_____ LAYOFF	_____ REMOVE DEPENDENT
_____ RE-ENROLLMENT	_____ CANCELLING COVERAGE	_____ OTHER
	_____ COBRA CONTINUATION	
	_____ CANCELLING COVERAGE	