



**\*(SECTION 4) OTHER HEALTH INSURANCE INFORMATION:**

Are you or any of your dependents covered by any other Health Care Plan?		<b>YES</b>	<b>NO</b>	If, YES, ALL QUESTIONS THAT APPLY MUST BE ANSWERED.	
Name of Policyholder		Relationship to You		SS# of Covered Person:	Date of Birth
Carrier		Policy Number		Effective Date	
Type of Plan:	Group	Individual	Medicare <small>COPY OF CARD REQUIRED</small>	Medicaid	Champus Other
Is the Covered Person retired?	NO	YES	If YES, enter date of retirement:		Cancellation date if applicable

**\*(SECTION 5) WAIVER FOR GROUP INSURANCE: Mandatory signature required below.**

I hereby decline coverage under my employer's group benefit plan(s).

Medical – PPO      Medical – Network Only      Kaiser      Dental – MetLife      Vision – UHC      Legal

By selecting "decline coverage" I hereby waive coverage under my employer's group plan and understand that if I desire such coverage hereafter I may be required to furnish medical evidence of insurability.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby apply for group benefits provided under my employer's group plan(s) and authorize payroll deduction, if required, for the cost of coverage. I certify that the information given on this enrollment form is complete and correct, and I understand that if the information is not complete and correct, this coverage could be retroactively terminated.

Employee's Signature \_\_\_\_\_ Date / / \_\_\_\_\_

Print Name \_\_\_\_\_