|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of employer/plan sponsor:** WMHIP – INSERT GROUP NAME | | | **Group #:** 71565 | | **Plan choice:**  \_\_\_\_\_ Insert Plan Name 1  \_\_\_\_\_ Insert Plan Name 2  \_\_\_\_\_ Insert Plan Name 3 | | | | | |
| **Check one:** | 🞏 Initial | 🞏 Change | 🞏 Termination | | 🞏 Reinstatement | | | | | |
| **Reason for change (check all that apply):**  🞏 Initial Eligibility Following Hire  🞏 Open Enrollment  🞏 Status Change:  🞏 Other: | | | | | **Date of hire:** | | | | | |
| **Occupation:** | | | | | |
| **Hours worked weekly:** | | | | | |
| **Effective date of coverage or change:** | | | | | |
| **Employee Name (last, first, middle initial):** | | | | | **Gender:** 🞏 Female  🞏 Male | | **Date of Birth:** | | **Social Security Number:** | |
| **Street Address:** | | | | | **Telephone (including area code):** | | | | | |
| **Email Address:** | | | | | Work: | | | Home: | | |
| **City:** | | | | | **State:** | | | **ZIP Code:** | | |
| **­Dependent’s Name** | | **Relationship**  **to Child** | | **Birth Date** | **Social Security Number** | | | **Gender** | | **Termination Date** |
| **Spouse:** | |  | |  |  | | | 🞏 Female  🞏 Male | |  |
| **Child:** | | 🞏 Natural  🞏 Step | |  |  | | | 🞏 Female  🞏 Male | |  |
| **Child:** | | 🞏 Natural  🞏 Step | |  |  | | | 🞏 Female  🞏 Male | |  |
| **Child:** | | 🞏 Natural  🞏 Step | |  |  | | | 🞏 Female  🞏 Male | |  |
| **Child:** | | 🞏 Natural  🞏 Step | |  |  | | | 🞏 Female  🞏 Male | |  |
| **Employee certification and signature:**   * To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent’s status. * The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings. * I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a “change in status” or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place. * **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.** * I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply. * I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements. | | | | | | | | | | |
| **Employee signature:** | | | | | | **Date:** | | | | |