Enrollment & Change Form
Initial Enrollment
Rehire
Change to Existing Enrollment*

EMPLOYER USE ONLY:

ColCal Inc.

DATE OF FULL-TIME HIRE	LOCATION/DIVISION	SALARIED HOURLY	SALARY (for salary based benefits)	OCCUPATION/JOB TITLE

Employee Information (please print, using blue or black ink)

Social Security Number	Last Name	First Name	MI

Mailing Address	Home Phone (include area code)	Work Phone (include area code)

City	State	ZIP Code	Date of Birth	Gender

Marital Status: Single Married Legally Separated Divorced Common-law/Domestic Partnership (Notarized Affidavit Required, see below*)

Benefit Choices

$1000 Plan / $5000 Plan	Dental	Vision
Employee Only	Employee Only	Employee Only
Employee + Spouse	Employee + Spouse	Employee + Spouse
Employee + Child(ren)	Employee + Child(ren)	Employee + Child(ren)
Employee + Family	Employee + Family	Employee + Family
No Medical (please complete waiver section)	No Dental	No Vision

*COMPLETE THIS SECTION ONLY IF YOU **DO NOT** WANT COVERAGE*

Waive Coverage for: Employee Spouse Child(ren)

Reason: Cost Other Coverage (Attach copy of ID Card)

I understand I (we) will not be able to enroll later unless special enrollment requirements are met or at open enrollment (if available). Pre-existing limitations may apply.

(sign here)______________________________

Change Information (Leave blank if initial enrollment or rehire)*

ADDITIONS

REASON FOR ADDITION:

Newborn – date of birth ______________________

Adoption – date of placement ______________________

Marriage – date of marriage ______________________

Involuntary loss of other coverage (Proof Required) Date:______________________

Other (explain)______________________

COMPLETE DEPENDENT INFORMATION SECTION, BELOW

TERMINATIONS

REASON FOR TERMINATION:

Divorce or Legal Separation (include ex-spouse's mailing address)

Dependent child no longer eligible

Voluntary termination (still eligible)______________________ (explain)

Other (explain)______________________

Qualifying Event Date: ______________________

Terminate Coverage for: ______________________

OTHER CHANGES

Name Change

Former name______________________

New name ______________________

Address/Phone # Change

Beneficiary Change: PLEASE MAKE CHANGES IN THE BENEFICIARY DESIGNATION BOXES ABOVE

Other (explain)______________________

Dependent Information (list only those members affected by the requested enrollment or change)

Mbr	Name (include last name if different)	Relation to Employee	Gender	Date of Birth (MM/DD/YY)	Social Security #
EE	**SEE ABOVE**	SELF	**SEE ABOVE**		
SP		Spouse by marriage Common Law Spouse or Domestic Partner			
CH					
CH					
CH					
CH					

* Please note: if Common Law Spouses and/or Domestic Partners are not eligible under your plan or in your state, a marriage certificate may be required.

For dependents age 19 and over, verification of dependent status, full-time student status **or** handicapped dependent status may be required prior to enrollment. Please check with your Employer or UMR for details and forms.

Are you or any of your dependents listed above currently covered under any other medical plan, including Medicare? No Yes, please provide the following information:

Member(s) Name(s)	Employer Name	Insurance Company or Employer Name, Address & Phone Number	Policy Number	Medicare A, B or both	Medicare HIC #

PLEASE PROVIDE A CERTIFICATE OF CREDITABLE COVERAGE (HIPAA CERTIFICATE) IF YOU HAVE HAD OTHER GROUP MEDICAL COVERAGE WITHIN THE LAST 12 MONTHS. If there is not proof of prior creditable coverage, pre-existing limitations as defined in the plan document may apply.

I acknowledge receipt of the benefit enrollment materials and certify that, to the best of my knowledge, the information shown on this form is correct and complete. I understand that I may not be able to make changes to these elections except in case of special enrollment or open enrollment (if available).

Employee Signature Date Signed

Effective Date	Location #	Plan #/Coverage/Class	Volumes	ID Card	Adjustment

Click to clear form: