Right CHOICE Benefit Administrators

Enrollment Form

RESET

PRINT

- ☐ New Enrollment
- ☐ Re-enrollment
- ☐ Reinstatement
- ☐ Late Enrollment
- ☐ Special Enrollment

SECTION A: To be completed by employer

Company Name _____ Location _____ Date _____

Date Employed Full Time _____ Waiting Period Start Date _____ Benefits Administrator Approval _____ Effective Date of Coverage _____

SECTION B: To be completed by employee

Plan Option _____ Deductible Amount _____

	Medical	Dental	Vision	Life AD&D
Single	☐	☐	☐	☐
Employee & Spouse	☐	☐	☐	☐
Employee & Child	☐	☐	☐	☐
Family	☐	☐	☐	☐

Last Name _____ First Name _____ Middle Initial _____ Soc. Sec. # _____

Address _____ Apt. No. _____ Home Phone _____ Work Phone

City _____ State _____ Zip code _____ Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SECTION C: Employees and family members to be covered

Relationship	NAME LAST	NAME FIRST	NAME MI	DATE OF BIRTH MO	DATE OF BIRTH DAY	DATE OF BIRTH YR	SEX M/F	Social Security #	Disabled	Full-Time Student	Medicare Eligible
EMPLOYEE											
☐ Husband ☐ Wife											
☐ Son ☐ Daughter ☐ Other											
☐ Son ☐ Daughter ☐ Other											
☐ Son ☐ Daughter ☐ Other											
☐ Son ☐ Daughter ☐ Other											
☐ Son ☐ Daughter ☐ Other											

SECTION D:

Other Health Insurance Coverage / Medicare

☐ YES ☐ NO

Type of Coverage: ☐ Medical ☐ Dental ☐ Both

Insurance Co. Phone # :

NAME OF INSURED WITH OTHER COVERAGE:

Social Security # _____ Birthday (m/d/y) _____

Name of Ins. Co. or Health & Welfare Plan: _____ Effective Date: _____

WHO IS COVERED? ☐ Spouse only ☐ Spouse & Children ☐ Spouse & Entire Family ☐ Insured & Spouse ☐ Insured & Children ☐ Spouse & Entire Family

EMPLOYER:

STREET ADDRESS:

CITY STATE ZIP CODE

Medicare Subscriber Medicare A ☐ Medicare B ☐ Date _____

Medicare Subscriber Medicare A ☐ Medicare B ☐ Date _____

Things you should know (Please read the following carefully)

1. I understand and agree no benefits shall take effect until this application is approved.
2. I understand that misrepresentation in answering the questions on this application, or non-payment of premium, may result in cancellation of coverage.
3. I understand that it is my responsibility to report to the Plan any change in the eligibility of myself or my dependents.

☐ I hereby request coverage and authorize deductions, if any from my pay for my portion of the cost of the benefits to which I may become entitled under this Plan.

☐ This is to certify that I have been given an opportunity to apply for Health Care benefits as offered by my above named employer, and that after careful consideration I have decided NOT to take advantage of this offer.

Please sign your name

Signature _____ Date _____

IMPORTANT:

1)If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you enroll within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement, for adoption, you may be able to enroll yourself and your dependents, provided that you enroll within 30 days after the marriage, birth, adoption, or placement for adoption after verification of loss coverage.

2)If you have a certificate of creditable coverage, please attach.