



COBRA/State Continuation Enrollment/Change Form

For non-medical enrollment or changes only

Employer Name: _____ Pending Paperwork Number: _____

Contact your benefits administrator for eligibility and available options. Employer Group Number: _____ Division Name: _____

ENROLLMENT/ CHANGE REASON

Enroll Change Terminate Other Reason: _____

EMPLOYEE INFORMATION

Employee Name		Date of Hire/Rehire/Retirement	Part- to Full-time Employment Date	Effective Date
Street Address	Apt #	Email	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	# of Hours worked per week: _____ Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> COBRA <input type="checkbox"/> Retired
City, State, ZIP	Home Telephone	Work Telephone	Do you or any dependents have Medicare? Part A ___ Part B ___ Both ___	

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS AND INDICATE ELECTIONS AT RIGHT. (Note that dependent coverage ends at age 26.)

Name (Last Name, First Name, Middle Initial)	Gender	Birth date MM/DD/YY	Social Security #	Medical	Dental	Vision	Critical Illness	Accident	Hospital Indemnity
Employee	<input type="checkbox"/> M <input type="checkbox"/> F								
Spouse Includes civil unions and domestic partners*	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								
Child	<input type="checkbox"/> M <input type="checkbox"/> F								

*A Domestic Partner Affidavit (if applicable) must be completed at the time of enrollment and retained by the employee. A copy must be provided to the employer. See cbia.com for a copy of the affidavit.

DENTAL (List all dependents you are enrolling above)

Voluntary - Ameritas

- Passive PPO 100%/80%/0%—\$750
- Passive PPO 100%/50%/50%—\$750
- Active PPO 100%/80%/50%—\$1,000
- Passive PPO 100%/80%/50%—\$1,000
- Passive PPO 100%/80%/50%—\$1,500 with ortho
- Waive

Group - Ameritas

- Active PPO 100%/100%/60% \$700
- Passive PPO 100%/80%/50% \$1,250
- Passive PPO 100%/80%/50% \$1,250 w/ Ortho
- Passive PPO 100%/80%/0% \$1,000
- Passive PPO 100%/80%/50% \$1,000
- Passive PPO 100%/80%/50% \$1,000 w/ Ortho
- Passive PPO 100%/80%/50% \$1,500
- Passive PPO 100%/80%/50% \$1,500 w/ Ortho
- Passive PPO 100%/80%/50% \$1,500 w/ Ortho
- Waive

VISION

Elect Waive

AUTHORIZATION AND ACCEPTANCE

I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information.

Important: The employee's signature is required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

Employee Signature _____

Date _____