

- Initial Enrollment
- Rehire
- Change to Existing Enrollment\*

**CoCal Inc. # 22207854**

**EMPLOYER USE ONLY:**

DATE OF FULL-TIME HIRE	LOCATION/DIVISION	<input type="checkbox"/> SALARIED <input type="checkbox"/> HOURLY	SALARY (for salary based benefits)	OCCUPATION/JOB TITLE
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**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
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common-law/Domestic Partnership (Notarized Affidavit Required, see below*)			

**Benefit Choices**

<input type="checkbox"/> \$5000 Plan <input type="checkbox"/> \$1000 Plan  <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family  <input type="checkbox"/> No Medical (please complete waiver section)	<input type="checkbox"/> + Dental  <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> No Dental	<p><b>WAIVED: COMPLETE THIS SECTION ONLY IF YOU DO NOT WANT COVERAGE</b></p> <p>Waive Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p>Reason: <input type="checkbox"/> Cost <input type="checkbox"/> Other Coverage (Attach copy of ID card)</p> <p>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.</p> <p>(sign here) _____</p>
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**Change Information (Leave blank if initial enrollment or rehire)\***

ADDITIONS	TERMINATIONS	OTHER CHANGES
<p><b>REASON FOR ADDITION:</b></p> <input type="checkbox"/> Newborn – date of birth _____	<p><b>REASON FOR TERMINATION:</b></p> <input type="checkbox"/> Divorce or Legal Separation (include ex-spouse's mailing address) _____	<input type="checkbox"/> Name Change Former name _____ New name _____
<input type="checkbox"/> Adoption – date of placement _____	<input type="checkbox"/> Dependent child no longer eligible	<input type="checkbox"/> Address/Phone # Change
<input type="checkbox"/> Marriage – date of marriage _____	<input type="checkbox"/> Voluntary termination (still eligible) _____ (explain)	<input type="checkbox"/> Beneficiary Change: PLEASE MAKE CHANGES IN THE BENEFICIARY DESIGNATION BOXES ABOVE
<input type="checkbox"/> Involuntary loss of other coverage (Proof Required) Date: _____	<input type="checkbox"/> Other (explain) _____ (explain)	<input type="checkbox"/> Other (explain) _____
<input type="checkbox"/> Other (explain) _____	<p><b>Qualifying Event Date:</b> _____</p> <p><b>Terminate Coverage for:</b> _____</p>	

COMPLETE DEPENDENT INFORMATION SECTION, BELOW

**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	* 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 CNIC Health Solutions for details and forms.
SP		<input type="checkbox"/> Spouse by marriage <input type="checkbox"/> Common Law Spouse or Domestic Partner				
CH						
CH						
CH						

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

**For CNIC Health Solutions Use Only**

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