

New Enrollment Change Open Enrollment COBRA Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER Greater Opportunites of the Permian Basin		GROUP NO. / ACCOUNT NUMBER F021756		LOCATION	
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO.	EARNINGS Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/>		JOB TITLE		CLASS
HOME ADDRESS			CITY	STATE	ZIP
HOME PHONE	WORK PHONE		CELL PHONE		

BENEFIT SELECTION - VISION

<p>ENROLLMENT Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate. (Choose One)</p> <p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Employee + Spouse</p> <p><input type="checkbox"/> Employee + Child(ren)</p> <p><input type="checkbox"/> Family</p>	<p>POLICY CHANGE (Check Reason for Change)</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Birth / Adoption</p> <p><input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Address Change</p>	<p>CANCEL COVERAGE</p> <p><input type="checkbox"/> Terminate Coverage Date <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p><input type="checkbox"/> Leave / Layoff</p> <p><input type="checkbox"/> Other Date <input type="text"/> / <input type="text"/> / <input type="text"/></p>
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COBRA CONTINUATION PRIVILEGE

Start Date: / /

Projected End Date: / /

Previously covered with group as:

1. Employee (termination, reduction in hours, other)

2. Spouse (divorce from employee, death of employee)

3. Dependent (reached age limit, married, no longer a Full Time Student, other)

4. Spouse & Dependents (divorce from employee, death of employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not include a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be available under state law if provided by the policyholder.

COVERED SPOUSE AND DEPENDENTS

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name	Last Name	Social Security Number	Date of Birth	Relationship	SEX <input type="checkbox"/> M <input type="checkbox"/> F	Adult Child FTS or HDCP	Name of Accredited School
				SPOUSE	<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		
					<input type="checkbox"/> M <input type="checkbox"/> F		

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR DEARBORN NATIONAL
USE ONLY

EMPLOYEE SIGNATURE _____

DATE / /

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE / /

EMPLOYER
Greater Opportunités of the Permian Basin

EMPLOYEE NAME - LAST FIRST