

## **Member Enrollment/Change Form**

Employer i	vame:											(	roup	Number:		
To Be Com	oleted by En	nployer <i>(thi</i> s	s section must l	be comp	oleted pri	or to su	bmittin	g to H	IPI)							
Hire Date:	ate: Effective Date:			Terminatio				on Date: Cha				nge Effective Date:				
Please indicate:	☐ Active	☐ Active ☐ COBRA Department/Division/Location (if applicable):														
Please indicate reason(s) for change or enrollment:	☐ Add Dep	☐ New Employee ☐ Open Enrollment ☐ Add Dependent Coverage; Reason: ☐ Terminate Dependent Coverage; Reason: ☐ Change of Status; Reason:				if requesting co					verage for employee's spouse:					
To Be Com										outer: _						
Employee Last Name			First Name				MI Social Sec			curity Number			Date of Birth			
Mailing Addre	ess		<u> </u>								ST		ZIP Code			
Gender	Marit	tal Status	En	Email Address								Prima	Primary Phone			
Health Cove	erage Election	on	Medical I	Plan Op	tion (if a	pplicab	le): _									
☐ Employee	e Only 🛚	Employee +	Spouse/Partne	er 🗆	] Employ	yee + C	hild(re	n)	□ E	mployee + I	Famil	у	☐ Em	ployee + Ex-	Spouse	
Dependents  Last Name		First Name			Gender	Date o	f Birth	R	Relationship to Employee		Sec	urity l	nt Socia Number		Drop Dependen	
									Linp	, oyee	(R	EQUI	RED)			
(if applicable) Medical P	•	urance Co.:	ents are covered													
Election of	Coverage		*	**Impor	tant***			То а	ccept	coverage,	select	YES	, sign, a	and date this	section.	
☐ YES •	terms of the representati	Plan. I authori ves. A photoco	der my employe ze any required opy shall be as vo ber of hours requ	deductio alid as th	ns from m ne original	ny earnir . • I certi	ngs. I au	ıthorize	e the re	elease of med	dical re	ecords	to Hea	Ith Plans, Inc.	(HPI) or its	
Signature:  Signature of Employee																
Waiver of C	overage															
□ NO •	covered und request enro or placemen	ler other health Illment within 3 t for adoption,	nent in the Plan f n insurance cove 30 days after you you may be able r placement for a	rage, yo ır other o e to enro	u may in t coverage e Il yourself	the futur ends. In	e be abi additior	e to er n, if you	nroll yo u have	ourself or you a new deper	r depe ndent a	ndent as a re	s in this esult of i	Plan, provided marriage, birth,	d that you adoption	
Signature	<u> </u>															
			Sianature	of Emn	lovee								Date	Sianed		

\*\*\* PLEASE RETURN COMPLETED FORM TO YOUR HUMAN RESOURCES DEPARTMENT \*\*\*