

District Council 37, Local 95

Head Start Employees Welfare

Employer: Complete Section A
Employee: Complete Section B-D

ENROLLMENT/CHANGE FORM

(PLEASE PRINT)

ACCOUNT INFORMATION

A	<input type="checkbox"/> Open Enroll <input type="checkbox"/> Change <input type="checkbox"/> New Enroll <input type="checkbox"/> Reinstatement		Effective Date: (MM/DD/CCYY)	Employer Name:	Employer Address:
	Acct. No.:	Job Title:	Date of Hire: (MM/DD/CCYY)	Agency:	Medical Benefit Option: <input type="checkbox"/> Single <input type="checkbox"/> Family
	Type of Change:		<input type="checkbox"/> Address Change <input type="checkbox"/> Family Security Benefit/Surviving Spouse		
	<input type="checkbox"/> Add Dependent(s)* Date:		<input type="checkbox"/> Retirement <input type="checkbox"/> Transfer to COBRA: <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos.		
	<input type="checkbox"/> Cancel Employee Last Date of Coverage:		<input type="checkbox"/> Other:		
	<input type="checkbox"/> Cancel Dependents(s)* Last Date of Coverage:		*List Names in Section B.		

PERSONAL INFORMATION

B	Employee Name (Last, First, M.I.):			Social Security No.:		
	Employee Date of Birth: (MM/DD/CCYY)	Home Phone:	Work Phone:	Home Email:	Employee I.D.:	
	Street Address:		City:	State: NY	Zip:	
	I would like coverage for me and my dependents: (Last, First, M.I.)			Dependent Social Security No.	Date of Birth	Gender
	Employee:					<input type="checkbox"/> M <input type="checkbox"/> F
	Spouse*:					<input type="checkbox"/> M <input type="checkbox"/> F
	Dependent*:					<input type="checkbox"/> M <input type="checkbox"/> F
	Dependent*:					<input type="checkbox"/> M <input type="checkbox"/> F
	Dependent*:					<input type="checkbox"/> M <input type="checkbox"/> F
	* Spouse and /or Dependent – Please attach proof of eligibility. List of acceptable documents available in Human Resources.					

OTHER HEALTH CARE COVERAGE

C	Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information on the next lines:					
	Name of Person Covered	Social Security No.	Effective Date	Medicare: Part A	Part B	Medicaid Other Insurance Carrier
	1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

SIGNATURE

D	Signature – The information provided above is true and correct to the best of my knowledge.		
	Employee's Signature/Date:	Spouse's Signature/Date:	Employer's Signature/Date: