



RETIREE BENEFITS ENROLLMENT FORM

EMPLOYEE # _____

NEW ENROLLMENT

CHANGE REQUEST

Social Security Number	Name – Last	First	MI	Home Phone ()
Home Address – Number & Street	City	State	Zip Code	
Sex (circle one) M or F	Birth Date / /	E-Mail Address		

CHECK THE TYPE OF PLAN AND COVERAGE LEVEL BELOW

Coverage	Single	Retiree + Spouse	Retiree + Dependents	Family
Humana PPO-1				
Humana PPO-2				
Humana HSA-1				
Humana HSA-2				
HSA Contribution	\$			
Medicare Adv.				
Delta Premier				
Delta PPO Plus				

Vision _____

MEMBERS List all members below. If additional space is required continue on back of form.

Last	First	MI	Date of Birth			Sex		Social Security Number
			MO	DAY	YR	M	F	
Policyholder								
Spouse								
Dependent								
Dependent								
Dependent								
Dependent								

STATUS CHANGES	CHANGE TO: (Check all that apply):	<input type="checkbox"/> Dependent Add/Delete (circle one):
	<input type="checkbox"/> Single Coverage	<input type="checkbox"/> Name Change: _____ Birthdate _____ Previous Name _____ Birthdate _____
	<input type="checkbox"/> Employee & Spouse Coverage	New Name _____ Reason: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death Date _____ <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other
	<input type="checkbox"/> Employee & Child(ren) Coverage	_____ <input type="checkbox"/> Dependent No Longer Eligible Reason: _____
<input type="checkbox"/> Family Coverage	<input type="checkbox"/> Terminate Coverage Reason: _____	

Signature: _____	Effective Date _____
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