



Sabine-Neches

ADMINISTRATORS, LC

ENROLLMENT CARD

COMPLETE BY PRINTING OR TYPING EXCEPT FOR SIGNATURE
20061213

P.O. Box 7306, Beaumont, TX 77726-7306 · (800) 825-2117

Employer/Group Name:

Group Number:

Office Use Only:
Location #
Effective Date:

Employee (Last Name) ▼	(First Name) ▼	(Middle Initial) ▼	Date of Birth:
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			Social Security Number:
Mailing Address:			<input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, ZIP:		Home Phone:	Work Phone:
Employment Status: <input type="checkbox"/> Active		<input type="checkbox"/> COBRA	
Coverage Selection			Date of Hire:
Employee Only (P00)	Medical	Dental	Occupation:
Employee + 1 (F00) / (P01)			
Employee & Family (F99) / (P99)			
If you have elected coverage for your spouse and / or children, you must complete the following information. Note: (1) Stepchildren, natural children and/or adopted children can be listed as Dependents <u>only</u> if the Employee's address is their primary residence, unless a child is a court-ordered Dependent Child of the Employee; (2) A court-ordered Dependent Child of the Employee is eligible only if a copy of the signed Court Order is submitted; (3) Any other child can be listed only if: (a) the Employee is the Legal Guardian of such Child, (b) a copy of the Legal Guardianship appointment is submitted, (c) the child resides with the Employee, and (d) proof is submitted that the child meets the IRS support/dependency guidelines.			

Dependent Full Name (Last, First, Middle)	SEX	Date of Birth	Soc. Security No.	Relationship	Full Time Student Y/N	Address (If different from Employee's)
Spouse:						

IMPORTANT***NOTICES AND ACKNOWLEDGMENTS*****IMPORTANT**

I hereby (1) request coverage for the Group Coverage(s) for which I am, or may become eligible, (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the coverage(s), and (3) designated the Beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. This selection is binding subject to my right to make changes according to the provisions of the Plan(s) and subject to any changes(s) required to comply with applicable government laws and regulation. I acknowledge and understand the following: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the applicable terms and conditions of the Master Group Contract(s), Plan Documents, and applicable government laws and regulations. These may require additional limitations and waiting periods. For insurance or benefits other than Health Coverage, you may be required to furnish at your own expense, satisfactory evidence of good health, and your application for such coverage(s) may be rejected. Your health Plan may impose a Pre-Existing Condition Exclusion or Limitation on an Employee or Dependent. Ask your Employer for a copy of the terms of any Pre-Existing Condition Exclusion. Individuals have the right to demonstrate creditable coverage, including the right to request a certificate from a prior plan or issuer of health coverage. If necessary, you may request assistance in obtaining a certificate for prior coverage(s) credit.

SIGNATURE _____ **DATE** _____



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Complete form on front and back pages

Spouse Coverage Information	If spouse is employed <input type="checkbox"/> Yes No	
	Are you or any listed dependents covered by any other Health or Dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>If "Yes" please fill out the following information</u>	
	Name of Insured/Policyholder:	Soc. Security # Date of Birth:
	Insured/Policyholder Employer with Address	
	Full/Part Time (Circle)	Work Number: Occupation:

Spouse/Dependent Other Coverage Information:				
Dependent Name	Other Health Plan Carrier	Carrier Address	Carrier Phone #	Policy #
1.				
2.				
3.				
4.				
5.				

Special Dependent Information (Complete This Section if Applicable)	If you are divorced, legally separated, a single parent, or dependents are from a previous marriage, please answer below		
	Please list dependents and address of each involved: _____ _____ _____	Who has the financial responsibility? Name and Address _____ _____	Employer Name _____
		(Relationship to listed dependent(s)) _____	Work Phone # _____
	Has the court decree established financial responsibility for the medical care of this child(ren) Y/N _____	Who has legal custody? Name and Address _____ _____	Employer Name _____
Relationship to listed dependent(s) _____		Work Phone # _____	

Medicare Coverage Information	Name of Person Covered	Medicare A (Hospital) Effective Date: ___/___/___	Medicare B (Medical) Effective Date: ___/___/___
	Reason for Medicare Eligibility <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal (Kidney) Disease <input type="checkbox"/> Disability & Current Renal Disease		
	Name of Person Covered	Medicare A (Hospital) Effective Date: ___/___/___	Medicare B (Medical) Effective Date: ___/___/___
	Reason for Medicare Eligibility <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal (Kidney) Disease <input type="checkbox"/> Disability & Current Renal Disease		

REFUSAL OF COVERAGE(S) This is to certify that I have been given an opportunity to enroll for group coverage(s) available to me through the above Employer, and I have decided NOT to apply for the following coverage(s) _____

I am refusing coverage because (state reasons) _____

SIGNATURE _____ **DATE** _____