

**ALDEN GLOBAL  
HRA ENROLLMENT / TERMINATION FORM**

**DATE OF HIRE:** \_\_\_ / \_\_\_ / \_\_\_

**EFFECTIVE DATE OF COVERAGE:** \_\_\_ / \_\_\_ / \_\_\_

**CONTRIBUTION:** \$ \_\_\_\_\_

**TERMINATION DATE:** \_\_\_ / \_\_\_ / \_\_\_

**COVERAGE STATUS:**     ACTIVE                       COBRA

**PERSONAL INFORMATION**

<b>PERSONAL INFORMATION</b>					
<b>NAME:</b>	LAST	FIRST	MIDDLE	<b>HOME PHONE NUMBER:</b>	
<b>ADDRESS:</b>	STREET	APARTMENT #	CITY	STATE	ZIP
<b>SOCIAL SECURITY #</b>	<b>DATE OF BIRTH</b>		<b>SEX</b>		
___ / ___ / ___	___ / ___ / ___		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
<b>MARITAL STATUS:</b>	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOW	<input type="checkbox"/> SEPARATED

**LIST THOSE DEPENDENTS (SPOUSE & CHILD[REN]) YOU WISH TO COVER UNDER THIS PLAN:**

- DEPENDENT(S)     ADD – EFFECTIVE DATE \_\_\_ / \_\_\_ / \_\_\_     SPOUSE     CHILD(REN)     DEPENDENT IS DISABLED  
 TERMINATE - EFFECTIVE DATE: \_\_\_ / \_\_\_ / \_\_\_    (DOCUMENTATION ATTACHED)

LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY #	FULL TIME STUDENT (TO AGE 23) SCHOOL NAME (DOCUMENTATION ATTACHED)

**CERTIFICATION AND SIGNATURE**

I CERTIFY THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FOR HR USE ONLY**

PROCESSED BY: \_\_\_\_\_ DATE \_\_\_\_\_

