INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

Employer Use Only

Group Name
Township of Wayne

Group ID | Employee Code

Effective Date Requested
/ /

Network | Division

Employer's Signature & Date

SECTION 1

Your Last Name | First | M.I.

Address

City | State | Zip Code

Your SS No. _____

☐ Single ☐ Married ☐ Divorced

In case of change due to Marriage: In case of change due to Divorce

Date of Marriage / / Date of Divorce / /

Phone No. ( ) ( )

Employment Status: Active: ☐ Full-time ☐ Part-time ☐ Retired ☐ COBRA

Date of Employment: / / Date of Retirement: / /

SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)
☐ Change Coverage to: (check new coverage)
☐ Cancel Coverage: (check those that apply)
☐ Add or Delete Dependent: (complete Section 4)
☐ Change Enrollee's Information: (complete Section 1 with new information)

REASON: _____

Type	Option	Single	Husband/Wife or Parent/Child	Parent/Children or Family	Complement to Medicare
Medical	Plan F	☐	☐	☐	☐
Medical	Plan G	☐	☐	☐	☐
Medical	Plan H	☐	☐	☐	☐
Medical	Plan I	☐	☐	☐	☐
Medical	Plan J	☐	☐	☐	☐
Medical	Plan K	☐	☐	☐	☐
Dental		☐	☐	☐	☐
Rx Copay		☐	☐	☐	☐

Date of change: / /

SECTION 3

OTHER COVERAGE? (Inaccurate information may result in claim delay or denial.)
Is there coverage under any other group health plan available to you or any member of your family?
☐ No ☐ Yes, Effective Date / /

If Yes; Policyholder Name & ID/SS No.

Relationship
☐ Self ☐ Spouse ☐ Child

Insurance Co. Name & Address

Birthdate
/ /

Policy #

Plan Type: ☐ Single ☐ Husband/Wife or Parent/Child ☐ Parent/Children or Family

Coverage Type: ☐ Medical ☐ Drug ☐ Dental ☐ Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

ADD	DELETE	RELATIONSHIP	DEPENDENT NAME Last	First	M.I.	Birth Date (mo/day/yr)	Full-time Student	ID/SS No.	Enrolled under Medicare A & B Effective Date
☐	☐	Self ☐ M ☐ F				/ /		- -	/ /
☐	☐	☐ Husband ☐ Wife				/ /		- -	/ /
☐	☐	☐ Son ☐ Daughter				/ /	☐ Yes ☐ No	- -	/ /
☐	☐	☐ Son ☐ Daughter				/ /	☐ Yes ☐ No	- -	/ /
☐	☐	☐ Son ☐ Daughter				/ /	☐ Yes ☐ No	- -	/ /

SECT 5

Do your dependents reside in your home?
☐ Yes ☐ No If No, give address:

Do you have a disabled dependent beyond initial limiting age?
☐ Yes ☐ No List Name(s):

Enrolled under Medicare? ☐ Yes ☐ No

Full-time students exceeding initial limiting age: (Must provide each semester to show Full-time student status)

List Names	School Name and Address	Expected Graduation

SECT 6

The Beneficiary selection applies to Life/Life with AD&D Insurance available through your Employer, if any. Selection(s) of Beneficiary(ies) is(are) not valid unless signed, dated and delivered to the Employer during your lifetime.

Primary – Full Name	Address	SS#	Relationship	% of Benefit
Secondary – Full Name				

Applicant's Signature _____ Date / /

For ALL coverage enrollments a Certificate of Creditable Coverage MUST be provided.