

ENROLLMENT AND CHANGE FORM

LAWRENCE TEACHERS ASSOCIATION

Type of Coverage: (where applicable) Contribution Type: C=Contributory	<input type="checkbox"/> Vision- GVS	<input type="checkbox"/> Hospital Indemnity	<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Accident	
<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Late Enrollee	<input type="checkbox"/> Rehire	Effective Date:	
<input type="checkbox"/> Change Enrollment / Beneficiary	<input type="checkbox"/> New Address	<input type="checkbox"/> Name Change, previous Name:			Effective Date:
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel Spouse/Partner and/or Dependent				Effective Date:	

A. Employee Information

Name (Last, First)			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
Street Address			Date of F/T Hire	
City	State	Zip	Hours worked per week	
Social Security No.		Email Address:		
Job Title	Home Phone		Work Phone	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			

B. Dependent Coverage (If more space is needed, attach extra copies)

Spouse/Partner's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Child's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	

C. Participation/Waiver

Request to Participate: I hereby request the policyholder to arrange the issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions from my earnings as my contributions toward the cost of insurance, if applicable.

Waiver of Insurance: I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required to participate in the plan at a later date.

Reason for refusing: Spouse/Partner's Plan Not Interested Other, please specify

The information provided above is true and complete to the best of my knowledge and belief.

Employee Signature: _____

Date: _____

Employer Representative: _____

Date: _____