

iba INTERNATIONAL BENEFITS ADMINISTRATORS L.L.C.
EMPLOYEE ENROLLMENT / CHANGE FORM

FOR OFFICE USE ONLY
 ENTERED _____
 I.D. _____
 RX _____
 TERMINATION _____

A. EMPLOYEE INFORMATION (1-17)

1. EMPLOYER'S NAME		
2. EMPLOYEE'S (LAST NAME)		(FIRST NAME)
3. ADDRESS		CITY
STATE	ZIP	COUNTY
4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH	6. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
7. COVERAGE <input type="checkbox"/> LIFE & AD&D <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> RX <input type="checkbox"/> VISION		
8. FAMILY STATUS <input type="checkbox"/> SELF ONLY <input type="checkbox"/> SELF & DEPENDENT CHILDREN <input type="checkbox"/> SELF & SPOUSE/FAMILY		
9. SPOUSE'S NAME	10. DATE OF BIRTH	11. SPOUSE'S EMPLOYER
12. DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, NAME OF CARRIER/PLAN		EFFECTIVE DATE:
13. PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED:		
NAME	RELATIONSHIP	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
14. PRIMARY BENEFICIARY/RELATIONSHIP	15. SECONDARY BENEFICIARY/RELATIONSHIP	
16. REQUEST FOR GROUP INSURANCE I hereby apply for insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued by my employer. I authorize the deduction if any, from my earnings of any contribution I am required to make toward the cost of this insurance. I understand that if I do not enroll when first eligible that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability. <input checked="" type="checkbox"/> _____ SIGNATURE DATE SIGNED _____		
17. WAIVER AUTHORIZATION I have been given an opportunity to apply for the group insurance offered to me through my employer. After serious consideration, I have decided not to take advantage of this offer, for the following coverages: <input type="checkbox"/> LIFE & AD&D <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> RX <input type="checkbox"/> VISION <input checked="" type="checkbox"/> _____ SIGNATURE DATE SIGNED _____		

B. TO BE COMPLETED BY EMPLOYER (18-24)

18. DATE OF HIRE	19. LOCATION	20. SALARY
21. DATE ELIGIBLE FOR COVERAGE	22. COBRA (WHEN APPLICABLE) DATE OF TERMINATION _____	18 MONTHS _____ OTHER _____ 36 MONTHS _____
23. TYPE OF TRANSACTION (CHECK ONE)		
ENROLLMENT <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REHIRE <input type="checkbox"/> RE-ENROLLMENT	TERMINATION <input type="checkbox"/> TERMINATING EMPLOYMENT <input type="checkbox"/> LAYOFF <input type="checkbox"/> CANCELLING COVERAGE	CHANGE <input type="checkbox"/> COBRA CONTINUATION <input type="checkbox"/> DEATH <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> REMOVE DEPENDENT <input type="checkbox"/> OTHER _____
24. INDICATE NAME OF ENROLLEES PPO NETWORK:		

WHITE/YELLOW - IBA COPY

PINK - EMPLOYER COPY