



GMS Mine Repair & Maintenance, Inc.



Internal Office Only:
Division _____

ENROLLMENT • CHANGE OF STATUS • TERMINATION REPORT

PLEASE INDICATE (CHECK ONE): New Enrollee Change of Status Late Enrollee Termination

EMPLOYEE'S INFORMATION (PLEASE COMPLETE FOR ALL REQUESTS):

1. Employee's Name _____	7. SSN or ID Number _____
2. Home Address _____	8. Group Number <u>3017</u>
3. Home Telephone () _____	9. Date of Employment _____
4. Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>	10. Effective Date of Coverage _____
5. Date of Birth _____	11. Remarks _____
6. Gender Female <input type="checkbox"/> Male <input type="checkbox"/>	_____

PPO DESIRED:

MEDICAL COVERAGE DESIRED:

OneNet PPO Beech Street MultiPlan Employee Only EE+ Child EE + Spouse Family

DEPENDENT'S INFORMATION (PLEASE COMPLETE FOR ALL REQUESTS):

Enroll the following dependents Terminate dependents listed below Terminate all dependents enrolled in plan

Name(s) of Dependents	Relationship to Employee	Social Security Number	Gender	Date of Birth
1. _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>	_____
2. _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>	_____
3. _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>	_____
4. _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>	_____
5. _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>	_____
6. _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>	_____
7. If any child is over age 18 and is enrolled as a full-time student, please indicate:				
Name & address of the school _____		date of full-time enrollment _____		to _____
Name & address of the school _____		date of full-time enrollment _____		to _____

COORDINATION OF BENEFITS INFORMATION (COMPLETE FOR ALL ENROLLMENTS OR CHANGES OF STATUS):

1. Is your spouse employed? Yes No
 Spouse's Employer: _____ Business Phone: _____
 Address: _____

2. Is your Spouse covered under his/her Employer's Group Health Plan? Medical Yes No

3. If you have children, are they covered as dependents under another Health Plan? Medical Yes No

4. If Questions 2 or 3 is answered Yes, please complete the following:
 Name of Insurance Company: _____
 Address: _____
 Certificate or ID Number: _____

MEDICAL AUTHORIZATION:

I hereby authorize release of any medical information necessary to process claims to or from Self Funding Administrators Corporation to or from any insurance company, employer, hospital, clinic, physician or pharmacy. This authorization shall apply to me and/or my covered dependents. I also authorize Self Funding Administrators Corporation to pay eligible benefits directly to any hospital or clinic that has rendered service to me or my dependents while covered under this health plan.

A photostatic copy of this Medical Authorization shall be considered as effective and valid as the original.

Employee's Signature _____ Today's Date _____

