CBX Dental, Vision, EAP, & Voluntary Employee Enrollment Application

Enrollment Reason:		
☐ New Hire ☐ Loss of Coverage (Date of Loss):_____ (HIPAA Certificate of Creditable Coverage Required)	☐ New Firm Enrolling ☐ New Enrollment (OE)	☐ Other Qualifying Event: _____ Event Date _____ ☐ Rehire/Re-Enroll (90 day limit)

SECTION 1: EMPLOYEE INFORMATION

Full-Time Date of Hire:	**Requested Effective Date:**	Effective date will be the 1st of the month following waiting period.
Name of Company	Job Title	
Last Name	First Name	M.I.
Social Security Number	**Date of Birth (mm / dd / yyyy)**	☐ Male ☐ Female
Email Address (required)		Home Phone
Residence Address (Physical Address, no PO boxes) Apt # City State		Zip Code
Mailing Address (If Different) Apt # City State		Zip Code
Marital Status ☐ Married ☐ Single ☐ Domestic Partner		

SECTION 2: BENEFIT SELECTION Please check below to enroll in the plans offered by your Employer.

If the company offers "Single Option", just select "Yes" or "No". If a Dual Option Choice is offered, also select the option you are choosing.

DENTAL PLAN: ☐ Yes ☐ No **If Dual Option**: ☐ Base Plan ☐ PPO Buyup	**VSP PLAN:** ☐ Yes ☐ No **If dual option:** ☐ Full Plan ☐ Mtls Only (you must have KP medical.)	**BLUE VIEW VISION:** ☐ Yes ☐ No	**LANDMARK Chiro or Chiro/Acupuncture (Must Match Medical):** ☐ Yes ☐ No	**ESPYR EAP** If offered by Co., 100% participation is required ☐ Yes

SECTION 3: DEPENDENT ENROLLMENT INFORMATION Do you have any legal dependents? ☐ Yes ☐ No

If you are enrolling any dependents in any plans, enter their information below. If not, please cross out the grid.

DEPENDENT GRID	SP/DP	CHILD #1	CHILD #2	CHILD #3
LAST NAME:				
FIRST NAME:				
SOCIAL SECURITY NUMBER:				
DATE OF BIRTH:				
GENDER:	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
RELATIONSHIP TO EMPLOYEE:	☐SP ☐DP			
DISABLED: [1]		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
DEPENDENT ENROLLING IN: [2] **(Only check plans that are offered)**	☐Dental ☐Vision ☐Chiro/Acu	☐Dental ☐Vision ☐Chiro/Acu	☐Dental ☐Vision ☐Chiro/Acu	☐Dental ☐Vision ☐Chiro/Acu

[1] For disabled dependents, please submit an Over Age Dependent Certification or Disabled Dependent Certification in addition to this form.
[2] Dependents may enroll up to age 26 (except on MetLife if married or not a student and not living at home).

SECTION 4: YOUR LEGAL ACKNOWLEDGEMENT: (Please Read, Sign and Date Below)

Employee Statement - I request group and/or voluntary coverage under my employer's group insurance plan as noted above and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable for this coverage.

X

EMPLOYEE SIGNATURE TO ENROLL IN COVERAGE **DATE**

PRINT NAME