

BENEFIT PLAN ADMINISTRATORS, INC.

101 SOUTH JEFFERSON ST. • ROANOKE, VA 24011 • 540/345-2721

EMPLOYER TO COMPLETE	EMPLOYER NAME	DATE OF HIRE
	LOCATION	OCCUPATION

EMPLOYEE ENROLLMENT FORM

 NEW EMPLOYEE

 REINSTATEMENT (please provide explanation)

APPLICANT'S NAME				SOCIAL SECURITY NO.			
APPLICANT'S ADDRESS				EMPLOYEE COVERAGE ELECTED Select only those applicable to your group health plan Volume			
<input type="checkbox"/> Male	BIRTH DATE	REGULAR HOURS WORKED	CLASS	LIFE AND AD&D	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Female	MONTH/DAY/YEA			SUPPLEMENTAL LIFE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> SEPARATED	SHORT TERM DIS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LIFE INSURANCE BENEFICIARY		SOCIAL SECURITY NUMBER	RELATIONSHIP	% PAYABLE	LONG TERM DIS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PRIMARY				MEDICAL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
CONTINGENT				DENTAL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
UNLESS OTHERWISE PROVIDED ABOVE, IF TWO BENEFICIARIES ARE NAMED, THE PROCEEDS SHALL BE PAID IN EQUAL SHARES TO THE NAMED BENEFICIARIES SURVIVING THE INSURED.				VISION	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

DO YOU WANT TO INSURE ELIGIBLE DEPENDENTS?

 Yes

 No

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	FULL TIME STUDENT	TOTALLY DISABLED	MEDICAL	DENTAL	VISION	DEP LIFE
SPOUSE			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHILD			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHILD			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHILD			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHILD			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ANY OF THE COVERED DEPENDENTS LISTED ABOVE ARE OVER AGE 19 AND A FULL TIME STUDENT, PLEASE COMPLETE SEPARATE STUDENT STATUS FORM.

ARE ANY COVERED DEPENDENTS COVERED BY OTHER INSURANCE?

 Yes

 No

IF YES, PLEASE PROVIDE THE FOLLOWING:

Dependent Name _____

Dependent SSN _____

Insurer Name/Address _____

Policy Number _____

Dependent Name _____

Dependent SSN _____

Insurer Name/Address _____

Policy Number _____

I hereby request to be insured. I further acknowledge that the plan may void my coverage if it finds that I misrepresented information on this application. When false or misleading information is discovered, the plan will have the right to take any and all steps to seek reimbursement for any and all claims paid.

MO/DAY/YR

FOR WAIVER OF EMPLOYEE GROUP INSURANCE - COMPLETE THE REVERSE OF THIS FORM