Security Administrative Services
P. O. Box 373
Mishawaka, IN 46546
1-800-550-4115
Fax 574-296-9970

GROUP ENROLLMENT / CHANGE FORM

☐ New Enrollment ☐ Other

☐ Dependent Add

Employer: WEST NOBLE

Group Number: 2001

HIPAA Certificate no longer needed as of 1/1/14

EMPLOYEE INFORMATION

Social Security #_____-_____-_____

Applicant Last Name _____ First_____ Middle_____ Phone# (_____)_____-_____

Address_____ City_____ State_____ Zip_____

Sex ☐ Male ☐ Female Date of Birth_____ Marital Status: Single Married Divorced Widowed

Hire Date _____ **Division:** (CIRCLE ONE) **Effective Date**_____
EMPLOYEE OR RETIREE

I hereby: Elect ☐ Decline ☐ **Medical (circle choice of coverage type)** **Plan Option 1** Single (MED2) Family (MED1)

I hereby: Elect ☐ Decline ☐ **Medical (circle choice of coverage type)** **Plan Option 2** Single (MED3) Family (MED4)

I hereby: Elect coverage under the Call-A-Doc Program _____Yes _____No

FAMILY MEMBERS TO BE COVERED ON THE WEST NOBLE PLAN:

Relationship	Last	First	M.I.	SS#	Sex (M/F)	Birthdate	Currently Covered by Another Plan? (*if yes see below)
Spouse						___/___/___	Yes ☐ No ☐
						___/___/___	Yes ☐ No ☐
						___/___/___	Yes ☐ No ☐
						___/___/___	Yes ☐ No ☐
						___/___/___	Yes ☐ No ☐

If married, is your spouse employed? Yes _____ No _____ If yes, where? _____

Does your spouse's employer offer health insurance? Yes _____ No _____ If yes, please complete the questions below*

* If employee, spouse or dependents are currently covered by another plan, please provide the name, address and phone numbers of the other Insurance Company:

Name of Dependent's Insurance Carrier: _____

Address: _____ Phone No: _____

AUTHORIZATION: By signing below, I authorize all physicians, Ph.D's, hospitals, druggists, and all agencies including other claim administrators to furnish to Self Insured Insurance Company and the health plan full information pertaining to the diagnosis and treatment of medical, mental, and drug & alcohol conditions. I understand that the purpose or need for this disclosure is to verify eligibility of benefits. I also understand that this consent is subject to revocation at any time through a written submission to the Insurance Company.

_____ _____ _____
(Employee's Signature) (Spouse's Signature) (Date)

_____ _____
(Employer Signature) ` (Date)