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) EMPLOYEE OR RETIREE **Effective Date**______________________

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)

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)