Medical Enrollment Application and Change Form

Name: _____ Date: _____

Gender: _____ SSN: _____ DOB: _____ Marital Status: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ email address: _____

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Benefit Election

***Coverage Level* (please circle):** Employee Only Employee + Spouse Employee +Child(ren) Family

Plan:

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Waiver of Coverage:

I choose to waive medical coverage at this time ☐

Waiver Reason: Covered by Spouse☐ Covered by Individual Policy☐ No Coverage☐ Other ☐

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Dependent Information:

Spouse: _____SSN: _____Gender: _____DOB: _____ add☐ term☐

Dep. 1: _____SSN: _____Gender: _____DOB: _____ add☐ term☐

Dep. 2: _____SSN: _____ Gender: _____ DOB: _____ add☐ term☐

Dep. 3: _____SSN: _____Gender: _____DOB: _____ add☐ term☐

Dep. 4: _____SSN: _____Gender: _____DOB: _____ add☐ term☐

For additional dependents, please attach an additional form

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Reason for application:

New hire enrollment ☐ Date of Hire ___/___/___ Termination☐ Date of Termination ___/___/____

Open Enrollment ☐

Qualified Life Event☐ *please enter date and check reason* Event Date ___/___/___

Marriage ☐ Birth/Adoption ☐ Divorce ☐ Loss/Gain of Coverage ☐

Other☐ Reason: _____

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I hereby authorize the action(s) indicated above, AND authorize my employer to deduct from my earnings the contributions necessary for my coverage. I also authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, or other medically related facility, insurance company, or other organization, institution or person that has any medical records for me or any of my dependents listed on this statement to give to the KBA or its agents any such information.

Employee Signature: _____ Date: _____

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To be completed by KBA member bank – THIS SECTION MUST BE COMPLETED FOR PROCESSING

Name of member bank: **Bank Code:** **Waiting Period:**

Effective date of coverage/change/termination: _____

Bank Representative: _____ Date:_____