

# ENROLLMENT FORM

TO BE COMPLETED BY EMPLOYER			
COMPANY NAME <b>Sarah Lawrence College</b>	GROUP NUMBER <b>JZ / JZ0000</b>	DATE OF HIRE	EFFECTIVE DATE
DIVISION #/NAME (Active / COBRA)		DEPARTMENT # / NAME (if applicable)	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Marriage	<input type="checkbox"/> Retirement	
<input type="checkbox"/> COBRA Open Enrollment	<input type="checkbox"/> Change Name	<input type="checkbox"/> Address Change	
<input type="checkbox"/> Change Employment Status	<input type="checkbox"/> Unpaid Leave of Absence	<input type="checkbox"/> Other _____	

EMPLOYEE INFORMATION:				
LAST NAME	MI	FIRST NAME	DATE OF BIRTH	
ADDRESS				
CITY	STATE	ZIP	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
SOCIAL SECURITY NUMBER	HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
EMPLOYEE FAMILY PHYSICIAN NAME OR PRACTICE NAME		PHYSICIAN ADDRESS		PHYSICIAN PHONE

HEALTH BENEFIT OPTIONS:	LEVEL OF COVERAGE:
MEDICAL <input type="checkbox"/> EPO Medical <input type="checkbox"/> PPO Medical <input type="checkbox"/> HDHP Medical <input type="checkbox"/> No Covg	<input type="checkbox"/> Employee <input type="checkbox"/> Family

DEPENDENT INFORMATION: List spouse and any dependent child who will be covered under your Health Benefit Option.				
Dependent #1: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Dtr <input type="checkbox"/> DP
Dependent #2: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Dtr <input type="checkbox"/> DP
Dependent #3: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Dtr <input type="checkbox"/> DP
Dependent #4: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Dtr <input type="checkbox"/> DP
Dependent #5: First & Last Name	Social Security Number	Date of Birth	Gender	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Dtr <input type="checkbox"/> DP

Date \_\_\_\_\_

Signature: \_\_\_\_\_