ENROLLMENT FORM

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

TO BE COMPLETED BY EMPLOYER			
COMPANY NAME **Sarah Lawrence College**	GROUP NUMBER **JZ / JZ0000**	DATE OF HIRE	EFFECTIVE DATE **1/1/2020**
DIVISION #/NAME (Active / COBRA)		DEPARTMENT # / NAME (if applicable)	

❒ New Enrollment ❒ Marriage ❒ Retirement
❒ COBRA Open Enrollment ❒ Change Name ❒ Address Change
❒ Change Employment Status ❒ Unpaid Leave of Absence ❒ Other _____

EMPLOYEE INFORMATION:					
LAST NAME	MI	FIRST NAME			DATE OF BIRTH
ADDRESS					
CITY	STATE	ZIP	GENDER ❒M ❒F	MARITAL STATUS ❒Single ❒Married ❒Separated ❒Widowed ❒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 ❒ EPO Medical ❒ PPO Medical ❒ HDHP Medical ❒ No Covg	❒ Employee ❒ 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
				❒Spouse ❒Son ❒Dtr ❒DP
Dependent #2: First & Last Name	**Social Security Number**	**Date of Birth**	**Gender**	**Relationship**
				❒Spouse ❒Son ❒Dtr ❒DP
Dependent #3: First & Last Name	**Social Security Number**	**Date of Birth**	**Gender**	**Relationship**
				❒Spouse ❒Son ❒Dtr ❒DP
Dependent #4: First & Last Name	**Social Security Number**	**Date of Birth**	**Gender**	**Relationship**
				❒Spouse ❒Son ❒Dtr ❒DP
Dependent #5: First & Last Name	**Social Security Number**	**Date of Birth**	**Gender**	**Relationship**
				❒Spouse ❒Son ❒Dtr ❒DP

Date _____ **Signature:** _____