



ANNUAL PARTICIPANT INFORMATION FORM

PLEASE PRINT

Employer Name _____ Employer Location _____

1. Employee Name _____ SS # _____

Marital Status: Single Married Divorced Common Law

Name and Social Security Number (REQUIRED) of Spouse and/or dependents:

Spouse: _____ SS# _____ Dependent: _____

Dependent: _____ Dependent: _____

Mailing Address _____ E-Mail _____ Phone # (____) _____

Street City State Zip

2. Is your spouse employed? Yes No If "Yes", please provide the following:

Employer Name (if self employed, explain on reverse) _____

Phone # (____) _____ Address _____

PLEASE COMPLETE #3 AND #4. YOU MAY SKIP TO #5 IF YOU DO NOT HAVE HEALTH BENEFITS THROUGH YOUR EMPLOYER'S PLAN.

3. Are you or any dependent (regardless of age) covered for health benefits by any other plan? (Include information about anyone for whom you are legally required to provide coverage.) Yes No If "Yes", please complete the following:

Name	SS#	Date of Birth	Type of Plan Group or Individual	Type of Coverage and Effective Dates		
				Medical Effective	Dental Effective	Vision Effective
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

4. If insurance is a Group Health Plan through another employer OR the coverage is Medicare, provide the following:

Who is the covered party? _____ SS# _____ Relationship _____

Type of Coverage: _____ Effective Date: _____

Through another employer: Yes No COBRA If COBRA, date coverage terminates _____

Name of Employer _____ Carrier Name _____

Employer Phone # (____) _____ Carrier Phone # (____) _____ Member ID _____

Through Medicare? Yes No If "Yes", Part A Effective Date _____
Part B Effective Date _____

Is the covered party? 65 or over and/or Totally Disabled 10 Digit Medicare ID# _____

5. If you declined medical benefits for yourself and/or your dependents through your employers plan, please complete this section.

Are you or your dependents covered under another plan? Yes No If yes, please complete the following:

Name	SS#	Date of Birth	Type of Plan Group or Individual	Type of Coverage and Effective Dates		
				Medical Effective	Dental Effective	Vision Effective
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

I certify that the information furnished by me in this form is true and correct.

Signature of Employee _____ Date _____