

HMS Enterprises GROUP ENROLLMENT FORM

ABOUT YOU (Use Black or Blue Pen) PLE	ASE PRINT CLEAR	LY					
Last Name	First Name		M.I.	Social Sec	urity Number -	Male Female	
Street Address		City/State	/ZIP	II.			
Occupation		Your Date of Birth			Hire Date		
, i		Mo.		Yr.	Mo. Day	Yr.	
Phone		En	nail				
	ingle	Divorce	ed [Married	☐ W	idowed	
COVERAGE ELECTION - MEDICAL							
Single Employee + Spouse							
Employee + Child(ren) Family							
☐ Waive Medical Coverage (See Note)							
NOTE: If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage,							
you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after							
your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth,							
adoption, or placement for adoption.							
DEPENDENT INFORMATION (You may be required to submit proof of Dependent Eligibility.)							
NAME	SOCIAL SE		RELAT	TONSHIP	DATE	DATE OF BIRTH	
	NUME	SEK					
	+						
A DOLLER VOLUE OPOLICE							
ABOUT YOUR SPOUSE In your Coases Familiared 2							
Is your Spouse Employed? Yes No	If "YES," Employer's Name, Address and/or Phone Number.						
Does Your Spouse have Health	If "YES," Name of Insurance Company and Policy Number.						
Insurance? Yes □ No □							
Yes ☐ No ☐ Health Single ☐ Family ☐							
	_						
Are you or any dependents on Medicare:	If "YES," Please provide copy of ID card						
☐ Yes☐ No							
NO			,				
EMPLOYER USE ONLY							
☐ NEW EMPLOYEE ☐ OPEN ENROLLMENT ☐ LATE ENTRANT							
SPECIAL ENROLLEE (STATUS CHANGE) - please explain be			Emplo	yee Signature	9	Date	
(Status Change) (Date)							
	(Date) _						
Effective Date							