



Eligibility Enrollment/Update

Check: Michigan Indiana Ohio DeltaUSA

Check one or both. Enrolling for: Dental Vision

Group Name: Kings Local Schools

Group#/Subgroup#

5630

3190

Subscriber Information (please complete for all enrollments/updates):

Example:

A	B	C	D	E	F	1	2	3	4
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Subscriber Name (Last)		(First)	(M.I.)	Sex Male Female
Subscriber Social Security Number	Birth Date	Status* Active Retiree	COBRA	Coverage Effective Date
Street Address				Check here if this is a new address
City		State	ZIP	

Plan Enrollment/Update Information (please indicate type of update and fill in appropriate information):

Type of Update: New Enrollment Reinstatement Change/Correction to Information Termination of Benefits

Group Transfer for: From: Group/Subgroup# To: Group/Subgroup# Rate Code Change* From: To: Effective Date of Change Change is Subscriber

Enrollment/Corrections to Information (please fill in for spouse/dependents for first-time enrollment or corrections):

SPOUSE Name (Last)		(First)	(M.I.)	Sex Male Female
Social Security Number	Birth Date	Status* Legal		
DEPENDENT #1 Name (Last)		(First)	(M.I.)	Sex Male Female
Social Security Number	Birth Date	Status* IRS Dep. <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/>		
DEPENDENT #2 Name (Last)		(First)	(M.I.)	Sex Male Female
Social Security Number	Birth Date	Status* IRS Dep. <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/>		
DEPENDENT #3 Name (Last)		(First)	(M.I.)	Sex Male Female
Social Security Number	Birth Date	Status* IRS Dep. <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/>		
DEPENDENT #4 Name (Last)		(First)	(M.I.)	Sex Male Female
Social Security Number	Birth Date	Status* IRS Dep. <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/>		

*See reverse side for instructions and explanation of

1 Subscriber's Signature _____ Date _____