

CBJ Enrollment and Change Form

Part 1. Employee Information			
Employer Name	Employee Social Security Number	Employee Birth Date	
Employee Name (LAST) (FIRST) (MI)	Home Phone	Marital Status	
Mailing Address	Work Phone	<input type="checkbox"/> Single	State
	City	<input type="checkbox"/> Married	

Part 2. Must Be Completed by CBJ Human Resources			
Medical Group No. 9001303	Dental Group No.	Date of Hire	Effective Date
Please check appropriate enrollment box and provide date:			
<input type="checkbox"/> New Employee	<input type="checkbox"/> Rehired Employee	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Transfer from other Plan
<input type="checkbox"/> Entered Eligible Class	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth
<input type="checkbox"/> Dependent Change	<input type="checkbox"/> Medical Child Support Order	<input type="checkbox"/> Adoption	<input type="checkbox"/> Death
<input type="checkbox"/> Active to Retired Status	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Other Reason:	

Part 3. Product Selection (Please Check Applicable Boxes)			
Economy Plan <input type="checkbox"/> Employee \$0 biweekly <input type="checkbox"/> Family \$88.20 biweekly	Standard Plan <input type="checkbox"/> Employee \$70 biweekly <input type="checkbox"/> Family \$155.40 biweekly	Basic Dental Plan <input type="checkbox"/> Employee No additional cost <input type="checkbox"/> Family No additional cost	Dental Buy Up <input type="checkbox"/> Employee \$12.46 biweekly <input type="checkbox"/> Family \$24 biweekly

Part 4. Enrollment							
Add	Drop	Relationship to Employee	Name (Last, First, Middle Initial)	SSN	Gender (M/F)	Birthdate MM/DD/YY	Mentally / Physically Disabled
<input type="checkbox"/>	<input type="checkbox"/>	Self					N/A
<input type="checkbox"/>	<input type="checkbox"/>	Spouse					N/A
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/> Yes

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

Employee Signature

Date Signed