



Subscriber Information					
SSN	Last Name	First Name	MI		
Home Address		City	State	Area Code/Home Phone	
Zip Code	County	Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Sex	Date of Birth

List all persons to be enrolled:											
	LAST NAME	FIRST NAME	M I	S E X	DATE of BIRTH MMDDYYYY	SOCIAL SECURITY #	* REL Code	BCN ONLY PCP Name	PCP CODE BCN Only	Med	Dent
Subscriber										<input type="checkbox"/>	<input type="checkbox"/>
Spouse										<input type="checkbox"/>	<input type="checkbox"/>
Dep-1										<input type="checkbox"/>	<input type="checkbox"/>
Dep-2										<input type="checkbox"/>	<input type="checkbox"/>
Dep-3										<input type="checkbox"/>	<input type="checkbox"/>

Relationship Codes for Dependents			
N – Child (by Birth or Adoption)	P – Principal Support	SD – Sponsored Dependent	C – Court Order Coverage (QMCSO) - attach documents
S – Stepchild	A – Child Adoption in Process	L – Legal Guardianship	F – Family Continuation Rider 19 +
		D – Disabled Child (PA275) - attach documents	

Hire Date	Effective Date	Occupation/Title	Hourly Wage	Hours Per Wk	Medical Group #	Service Code	Dental Group #	Division	Class
							408730		

Medical	Single	EE + 1	Family	Rider
CBPPO	<input type="checkbox"/> \$91.74	<input type="checkbox"/> \$181.48	<input type="checkbox"/> \$211.36	<input type="checkbox"/> \$52.21
CBPPO 12	<input type="checkbox"/> \$73.52	<input type="checkbox"/> \$140.46	<input type="checkbox"/> \$162.16	<input type="checkbox"/> \$43.10
BCN	<input type="checkbox"/> \$71.56	<input type="checkbox"/> \$141.17	<input type="checkbox"/> \$153.91	<input type="checkbox"/> \$41.60
BCN Basic	<input type="checkbox"/> \$63.48	<input type="checkbox"/> \$125.97	<input type="checkbox"/> \$137.55	<input type="checkbox"/> \$36.72
Waived*	<input type="checkbox"/> Reason: Covered under <input type="checkbox"/> spouse <input type="checkbox"/> other <input type="checkbox"/> parents			

Dental	Single	EE + 1	Family
GLPPO	<input type="checkbox"/> \$7.29	<input type="checkbox"/> \$15.47	<input type="checkbox"/> \$19.45
GLDHMO	<input type="checkbox"/> \$4.32	<input type="checkbox"/> \$6.91	<input type="checkbox"/> \$12.33
Facility # DHMO Only	Office Code:		
Waived*	<input type="checkbox"/> Reason: Covered under <input type="checkbox"/> spouse <input type="checkbox"/> other <input type="checkbox"/> parents		

Life/Disabilities	Group #
Short-term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____
Long-term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____
Life Insurance	<input checked="" type="checkbox"/> No Cost \$15,000.00

Life Insurance Beneficiary		
Name _____	Relationship _____	Percentage _____
Name _____	Relationship _____	Percentage _____

Signature	Date	
		<small>*As an employee of TAC Transportation I hereby certify that I have been afforded an opportunity to enroll for Group Health Insurance by said employer and after careful consideration have decided not to enroll. It is my understanding that in the event that I desire such insurance hereafter I shall be required to submit a fully completed health insurance application to my employer prior to the commencement of said Group Health Insurance Benefits during open enrollment.</small>
		Initials _____