RetaEnroll

132 Ivy Lane
King of Prussia, PA 19406
Phone: (877) 303-7382
Fax: (877) 332-7382

ENROLLMENT / CHANGE FORM

This form can be used as an initial enrollment or to report a change in information. Please complete all information by printing clearly and firmly or by typing. If additional space is needed, please attach a statement with the appropriate information. Please check the applicable boxes below. **Please note this document is to be used only for those coverage's administered by the Reta Enroll system.**

❒ New Enrollment ❒ Waiver ❒Transfer from Location #_____ to #_____ ❒Terminate ❒Life Event

Location Name	Location Number	Phone Number

I. EMPLOYEE INFORMATION

Date of Hire	Class	Effective Date	DOB	Annual Salary $_____	Hours Worked / Week	Marital Status	Date of Marriage

Last Name	First	MI	Soc. Sec. No.	Sex (M/F)

Street Address	City	State	Zip	Home Phone (including area code) ( )

E-Mail	Work Phone (including area code) ( )

II. COVERAGE ELECTION (complete dependent information section if coverage elected for spouse and/or children)
DEPENDENTS ELECTING COVERAGE IN THE SAME MEDICAL/VISION OR DENTAL PLANS AS THE EMPLOYEE.

Coverage	Plan Name / Benefit Amount	Employee	Spouse	Child(ren)	Add/Term	Comments / PCP #
Medical		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No		
Dental		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No		
Vision		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No		
Employee Life/AD&D		❒Yes ❒No				
Spouse Life/AD&D			❒Yes ❒No			
Child Life/AD&D				❒Yes ❒No		
Voluntary Short Term Disability		❒Yes ❒No				
Voluntary Long Term Disability		❒Yes ❒No				

III. DEPENDENT INFORMATION (Required if dependent coverage is to be added of changed)

Name	SSN	Relationship	Sex (M/F)	DOB	Full Time Student	Handicapped	Add/Term (A/T)	**Only For Dependents on PacifiCare** PCP #

IV. BENEFICIARY INFORMATION (Complete if Enrolling in any Life/AD&D Program)

Name	Relationship	Date of Birth	Primary/Contingent	% Breakdown

V. RELEASE

I hereby acknowledge that I have read and understand the informational materials provided by my employer explaining my available benefits and the enrollment process.

I acknowledge that the benefit elections confirmed by me, are irrevocable and may not be changed until the next plan year unless I experience a Permitted Election Change and follow the procedures as described in the informational materials for making such a change. By signing below, I authorize that required contributions be made, through payroll deduction, for the benefits that I elected and confirmed by me, and such authorization is voluntary.

This authorization is effective immediately and shall remain in effect for use in connection with any claim for benefits for as long as any health coverage may be in effect. A photocopy of this authorization is as valid as the original.

THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTOOD, AND AGREE TO ALL SECTIONS AND THE TERMS OF THIS ENROLLMENT FORM.

SIGNATURE X_____ **Date**_____
(Required)

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TO BE COMPLETED BY LOCATION ADMINISTRATOR ONLY

VI. REASON FOR THE CANCELLATION / CHANGE

EMPLOYEE COVERAGE:

❒ Discharged
❒ Retirement
❒ Reduction in work hours
❒ Deceased
❒ Birth/Adoption of Child
❒ Resignation: Date Submitted
❒ Increase in work hours
❒ New Address
❒ Marriage
❒ Other please specify: _____

DEPENDENT COVERAGE:

❒ Death of covered employee
❒ No longer an eligible dependent
❒ Date of divorce / legal Separation
❒ Termination of dependent's health coverage
❒ Eligible for Medicare
❒ Marriage

Name of person completing this section (Please Print)	Signature	Date