Enrollment/Change Form for Medical, Dental & Vision Insurance

Please print legibly and return completed form to Human Resource Services.

Subscriber Information: ☐ New Enrollment ☐ Change ☐ Delete

Employee First, MI, Last Name (print): _____

Employee Social Security Number: _____-_____-_____

Date of Birth (MM/DD/YYYY): _____/_____/_____ ☐ Male ☐ Female

Address_____

City _____ State_____ Zip Code_____

I elect the following plan(s)

☐ Medical – HealthAmerica/HealthAssurance ☐