



HEALTH BENEFIT PLAN ENROLLMENT FORM

COMPLETE ALL SECTIONS BELOW FOR NEW ENROLLMENTS. INCOMPLETE FORMS WILL BE RETURNED. PLEASE COMPLETE THE OTHER HEALTH INFORMATION SECTION ON THE BACK AND REVIEW THE HIPAA PORTABILITY RIGHTS STATEMENT.			Company / Employer Name:				
EMPLOYEE NAME (FIRST) (INITIAL) (LAST)			Type of Benefits: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Disability <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Other				
			SOCIAL SECURITY NO. (required by law) SEX (M OR F) BIRTH DATE _____ - _____ - _____				
ADDRESS			DATE OF HIRE <input type="checkbox"/> Single <input type="checkbox"/> Widowed _____ - _____ - _____ <input type="checkbox"/> Divorced <input type="checkbox"/> Married - Marriage Date _____ - _____ (Required If Enrolling Spouse)				
CITY STATE ZIP			FOR COMPANY USE ONLY				
(AREA CODE) PHONE NUMBER			PLAN# DEPT. EFFECTIVE DATE				
OCCUPATION/JOB TITLE EARNINGS (for Disability or Life Ins.) _____ \$ _____ PER _____							
BENEFICIARY (FIRST) (INITIAL) (LAST)		BIRTH DATE _____ - _____ - _____		RELATIONSHIP			
ADDRESS (STREET) (CITY) (STATE) (ZIP)			(AREA CODE) PHONE NUMBER				
DEPENDENTS (Use additional paper, if necessary.) If you are <u>not</u> covering a dependent, please fill out the waiver on the back of this form also.							
FIRST	INITIAL	LAST	SOCIAL SECURITY NUMBER <small>(required by law)</small>	BIRTH DATE	SEX	RELATIONSHIP	TO BE COVERED YES / NO
LEGAL SPOUSE							
List Child							
List Child							
List Child							
List Child							
Any dependents listed above must meet the definition of a dependent as listed in the Summary Plan Description. If a dependent child is 18 or older, is he/she eligible for group health coverage through his/her own employer? <input type="checkbox"/> Yes <input type="checkbox"/> No. Is he/she entitled to benefits under Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No							

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on this Enrollment Form may be considered health care fraud.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

I ACKNOWLEDGE receipt of the HIPAA Portability Rights statement furnished to me with this form.

I have prior creditable coverage Yes No. If yes, I understand I must submit a certificate of creditable coverage to TPM.

SIGNATURE OF APPLICANT

DATE

**COMPLETE WAIVER FORM ON BACK IF YOU AND/OR YOUR DEPENDENTS
CHOOSE NOT TO BE COVERED BY THIS HEALTH BENEFIT PLAN**

