



## GROUP BENEFITS ENROLMENT FORM

<b>Member Name</b>  <small>First Middle Init. Last</small>	<b>Union ID #</b>
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<b>SECTION 1 SPOUSE INFORMATION</b>	<b>Marital status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Common Law <input type="checkbox"/> Married/Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	If common law, date cohabitation started:	M	D	YYYY	
	<small>First Name Middle Init. Last Name</small>			<b>Spouse Date of Birth</b>	<b>Sex</b>		
				M D YYYY	<input type="checkbox"/> Female <input type="checkbox"/> Male		
	<input type="checkbox"/> My spouse does not have extended health and/or dental coverage	<input type="checkbox"/> My spouse has the following benefits:	Extended Health: <input type="checkbox"/> Single <input type="checkbox"/> Family				
			Dental: <input type="checkbox"/> Single <input type="checkbox"/> Family				
		<b>Spouse group policy number</b>	<b>Spouse ID#</b>	<b>Spouse insurance company</b>	<b>Spouse employer</b>		

<b>SECTION 2 DEPENDENT INFORMATION</b>  <i>Please list all dependents.</i>	<b>First Name</b>	<b>Last Name</b> <small>(only if different from employee)</small>	<b>Middle Initial</b>	<b>Sex</b>	<b>Date of Birth</b>	<b>For children age 21 or older please specify:</b>		
	Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	<small>Full time student</small>	<small>Disabled Dependent</small>	
						Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
							Name of School and ID#	
	Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
							Name of School and ID#	
	Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
							Name of School and ID#	
Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		
						Name of School and ID#		
Child			<input type="checkbox"/> Female <input type="checkbox"/> Male	M D YYYY	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>		
						Name of School and ID#		

If you have additional dependents please list them on a separate sheet and attach to this form.

