



# GROUP ENROLLMENT / CHANGE FORM

Employee's First Name

Employee's Last Name

## SECTION 1: EMPLOYER / EMPLOYEE INFORMATION

EMPLOYER Name:						Waiting Period: _____ Days	
SSN:	Date of Birth:	Gender:	FT or PT:	Home EMAIL address for delivery of benefit plan documents:			
Mailing Address:				City:	State:	Zip:	
Date of Hire/Rehire/or Became Full Time:	Effective Date (VADA use only):	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Party to a Civil Union <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single					

## SECTION 2: NEW ENROLLMENT

New Hire     Rehire (if within 6 months)     Open Enrollment     New Group

Transfer from other VADA Group Name: \_\_\_\_\_

## SECTION 3: CHANGE (Check all that apply)

Date of Event: \_\_\_\_\_  Birth     Adoption     Marriage/Civil Union     Divorce     Death     Loss of Coverage\*\*  
 Enter/Discharge from Military     Court Ordered Change\*\*     Add/Remove Spouse/Civil Union or Dependent     Address Change  
 Name Change    Other (explain): \_\_\_\_\_    **\*\*Additional Documentation Required**

## SECTION 4: LIST ALL DEPENDENTS BELOW

Subscriber:	Last Name:	
Add	First Name:	
Health    Dental    Vision		
Spouse/CU Partner/Dom. Partner	Last Name:	Female
Add    Remove	First Name:	Male
Health    Dental    Vision	SSN:***	Date of Birth
Dependent Child:	Last Name:	Female
Add    Remove	First Name:	Male
Health    Dental    Vision	SSN:	Date of Birth
Incap dependent 26/older		
Dependent Child:	Last Name:	Female
Add    Remove	First Name:	Male
Health    Dental    Vision	SSN:	Date of Birth
Incap dependent 26/older		
Dependent Child:	Last Name:	Female
Add    Remove	First Name:	Male
Health    Dental    Vision	SSN:	Date of Birth:
Incap dependent 26/older		
Dependent Child:	Last Name:	Female
Add    Remove	First Name:	Male
Health    Dental    Vision	SSN:	Date of Birth:
Incap dependent 26/older		

**PLEASE SEE SECTION 11 ON REVERSE SIDE FOR SUBSCRIBER SIGNATURE**

\*\*\* = SSN required age 45 and older (federal mandate requires the collection of SSN)

**SECTION 5: LIFE INSURANCE BENEFITS**

Life Insurance Option: \$5K, \$10K, \$15K, \$25, \$50K	Primary Beneficiary:	Secondary Beneficiary:	Annual Salary:
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**SECTION 6: HEALTH INSURANCE BENEFITS**

Health Plan Option:	<b>MVP Group #</b>	Health Plan Type:	1 Person	2 Person	Family	Refusal
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**NEW EMPLOYEES ONLY** – Do you have existing healthcare coverage that you are replacing with this coverage? Yes No

**SECTION 7: DENTAL INSURANCE BENEFITS**

Dental Plan Option:	NEDD Group No:	Dental Plan Type:	1 Person	2 Person	Family	No Benefit
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**SECTION 8: DELTAVISION INSURANCE BENEFITS**

Vision Plan Option:	DeltaVision Sublocation:	Vision Plan Type:	1 Person	2 Person	Family	No Benefit
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**SECTION 9: SHORT-TERM DISABILITY INCOME BENEFITS**

Benefit Plan Option:	Weekly Earnings:	No Benefit
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**SECTION 10: OTHER INSURANCE**

After you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare)?  
Yes (If yes, please complete the applicable section(s) below) No

**Medicare**

Name of Medicare Subscriber:	Social Security No.:	Medicare/HIC No.:	Part A Effective Date:	Part B Effective Date:
Health		Dental		
Health Insurance Company Name:	Dental Insurance Company Name:			
Address:		Address:		
Policy Holder Name:	Policy/Certificate No.:	Policy Holder Name:	Policy/Certificate No.:	
Effective Date:	Type of Coverage:	Effective Date:	Type of Coverage:	

**SECTION 11: EMPLOYEE & GROUP BENEFIT MANAGER SIGNATURES**

I certify that the statements on this enrollment form and all information furnished by me are true and complete to the best of my knowledge. I authorize my employer to provide information about my employment to the VADA Insurance Trust for purpose of verifying or determining my eligibility for benefits. I certify that I work for a Participating Company for a minimum of 17.5 hours per week or the minimum number of hours per week required by my employer for eligibility, whichever is more; and that I perform my work at a Participating Company’s VADA member business location. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is issued by VADA Insurance Trust. I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

**SIGN HERE:**

Employee/Subscriber’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Group Benefit Manager’s Signature \_\_\_\_\_ Date \_\_\_\_\_