

NATIONAL BENEFITS, INC.

ENROLLMENT APPLICATION

NAME OF EMPLOYER:				EFFECTIVE:	
GROUP NO.	S.S.#	DATE OF HIRE	Loc #	ORIGINAL DATE OF COVERAGE WITH EMPLOYER	EFFECTIVE DATE OF COVERAGE WITH NBI
I APPLY FOR <input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD <input type="checkbox"/> DENTAL ONLY <input type="checkbox"/> LIFE ONLY <input type="checkbox"/> COBRA <input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY <input type="checkbox"/> I DECLINE COVERAGE					
EMPLOYEE NAME _____					
		LAST NAME	FIRST NAME	MIDDLE INITIAL	
ADDRESS _____			APT. NUMBER	<input type="checkbox"/> M DATE OF BIRTH _____ <input type="checkbox"/> F MONTH DAY YEAR	
CITY	STATE	ZIP CODE		NETWORK:	

DEPENDENT INFORMATION

NAME OF SPOUSE _____	DATE OF BIRTH _____	MONTH	DAY	YEAR	IS SPOUSE EMPLOYED?
IF SPOUSE EMPLOYED PLEASE PROVIDE EMPLOYERS NAME & ADDRESS _____					
DOES YOUR SPOUSE HAVE OTHER INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF COVERAGE		
IF YES PLEASE PROVIDE THE NAME & ADDRESS & PHONE # OF THE OTHER INSURANCE CARRIER _____			<input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD <input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY		
NAME OF CHILD _____	DATE OF BIRTH _____	MONTH	DAY	YEAR	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> DISABLED
NAME OF CHILD _____	DATE OF BIRTH _____	MONTH	DAY	YEAR	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> DISABLED
NAME OF CHILD _____	DATE OF BIRTH _____	MONTH	DAY	YEAR	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> DISABLED
NAME OF CHILD _____	DATE OF BIRTH _____	MONTH	DAY	YEAR	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> DISABLED
NAME OF CHILD _____	DATE OF BIRTH _____	MONTH	DAY	YEAR	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> DISABLED
LIFE INSURANCE AMOUNT \$ _____					
BENEFICIARY DESIGNATION _____					
		NAME	RELATIONSHIP		
ADDRESS _____					
ENROLLED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, WHAT DATE ENROLLED? _____		
ADDITIONAL INFORMATION					
* IF FULL-TIME COLLEGE STUDENT, PLEASE PROVIDE PROOF OF FULL TIME STATUS IN THE FORM OF A SEMESTER BILL.					
EMPLOYEE SIGNATURE _____			DATE _____		
I REPRESENT THAT EACH OF THE ABOVE STATEMENTS AND ANSWERS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.					