

NORTH AMERICA ADMINISTRATORS, L.P. ENROLLMENT FORM

Employer _____	<input type="radio"/> Full-Time	<input type="radio"/> Retiree
Department _____ Class: _____	<input type="radio"/> COBRA	<input type="radio"/> Reinstatement of Coverage
<input type="radio"/> Hourly <input type="radio"/> Salaried <input type="radio"/> Union		

EMPLOYEE INFORMATION

Employee Name:	Last	First	Middle Initial	Social Security Number	Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth (Mo./Day/Yr.)
Email Address	MARITAL STATUS <input type="radio"/> Single <input type="radio"/> Married			COVERAGE ELECTIONS <input type="radio"/> Standard Medical <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Life <input type="radio"/> Dependent Life <input type="radio"/> Supplemental Life <input type="radio"/> Disability Income <input type="radio"/> LTD		VOLUME _____ _____ _____ _____
Street Address						
City	APPLY FOR: <input type="radio"/> Self <input type="radio"/> Self & Spouse <input type="radio"/> Self & Children <input type="radio"/> Self & Family					
State				Zip	County	
Name of Beneficiary: Last				First		Middle Initial
						Relationship

HIRE DATE _____
EFFECTIVE DATE _____
REMARKS _____
OFFICE USE ONLY
PROCESSED DATE _____
USER I.D. _____

USE THE SPACE BELOW TO LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER. Last name required if different from employee's. If any dependent has a different address please note dependent number (i.e., #1, 2, 3, etc.) and address on back of form.

1. Spouse's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="radio"/> M <input type="radio"/> F	Social Security Number	Relationship	Full Time Student <input type="radio"/> Yes <input type="radio"/> No
2. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="radio"/> M <input type="radio"/> F	Social Security Number	Relationship <input type="radio"/> Natural Child <input type="radio"/> Stepchild	Full Time Student <input type="radio"/> Yes <input type="radio"/> No
3. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="radio"/> M <input type="radio"/> F	Social Security Number	Relationship <input type="radio"/> Natural Child <input type="radio"/> Stepchild	Full Time Student <input type="radio"/> Yes <input type="radio"/> No
4. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="radio"/> M <input type="radio"/> F	Social Security Number	Relationship <input type="radio"/> Natural Child <input type="radio"/> Stepchild	Full Time Student <input type="radio"/> Yes <input type="radio"/> No
5. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="radio"/> M <input type="radio"/> F	Social Security Number	Relationship <input type="radio"/> Natural Child <input type="radio"/> Stepchild	Full Time Student <input type="radio"/> Yes <input type="radio"/> No
6. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="radio"/> M <input type="radio"/> F	Social Security Number	Relationship <input type="radio"/> Natural Child <input type="radio"/> Stepchild	Full Time Student <input type="radio"/> Yes <input type="radio"/> No

OTHER INSURANCE INFORMATION	
Are you or any of your dependents covered by other insurance? <input type="radio"/> Yes <input type="radio"/> No	
If yes, you must fill out the following information to qualify at any time as a Special Enrollee. (Attach separate sheet if additional space is required.)	
Name of Person Covered by Other Insurance	Social Security Number
Name of Other Employer	Group No.
Name of Other Insurance Company	
Address of Other Insurance Company	

I hereby apply for the coverage to which I am now entitled or to which I may become entitled under the provisions of the Group Plan or Plans issued through North America Administrators, L.P. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage by my employer.

I acknowledge that I have been given the opportunity to elect coverage under the group benefit plans and hereby decline coverage for the following: _____

I decline coverage because: _____

(YOU MUST COMPLETE "OTHER INSURANCE INFORMATION" IF APPLICABLE)

I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish North America Administrators, L.P. with full information regarding medical treatment (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish North America Administrators, L.P. with information regarding benefits to which I may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

EMPLOYEE SIGNATURE _____ DATE _____