



ENROLLMENT/WAIVER FORM

☐ ENROLLING

(Complete sections I, II, IV, and V)

☐ WAIVING

(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date 06/09/2023	Employer/Group Name MCDONALD'S CORPORATION	Group Number 32081881	Payroll Location
First Name JEANNE	MI	Last Name D'ARC	Social Security Number (If no SS#, write N/A): 980-51-4189
Address 2900 W OKLAHOMA AVE			
City MILWAUKEE	State IN	Zip 53215	County
Home/Cell Phone 765-239-9696			
Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married <input checked="" type="checkbox"/> Divorced		Enrollment Status <input checked="" type="checkbox"/> Active Employee <input type="checkbox"/> COBRA Continuant Start Date _____ <input type="checkbox"/> Rehired Employee <input type="checkbox"/> HIPAA Life Event (Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)	
Full-Time Hire (or Rehire) Date (Month/Day/Year): 08/02/2012		Hours Worked Per Week 60	
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Date of Birth (Month/Day/Year) 05/17/1975	Age 48	Product Selection(s) <input checked="" type="checkbox"/> Medical Product Name: _____ <input type="checkbox"/> Vision <input type="checkbox"/> Dental

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner [†]	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

[†]If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name TONY	MI M	Last Name STEIN	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input checked="" type="checkbox"/> Adopted* <input type="checkbox"/> Other*	
Social Security Number (If no SS#, write N/A) 980-51-4189		Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) 11/13/1994	Age 29
Product Selection(s): <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental			Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.