

complete sections I, II, IV, and V)

ENROLLMENT/WAIVER FORM OF DENROLLING
COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

WAIVING

(Complete sections I and III)

Name and He Augusta Home/Cell Phone County (819) 837-5185		a location in the second	oth enrollees and waivers)
Interesting the page of the pa	CONTRACT HOLDER INFORMA	TION (Must be completed for	Payroll Location
Last Name	I EMPLOYEE/CONTRACT	Group Number 184965	9 Seyman
Age   Product Selection(s);   Por Number (if no SSs, write NAI)   Control	11/0001	Social Security Nun	nber (If no 55%, write NA). 50 - 6681
County   C	it Name 1 1 If dugustar		
arial Status (Please check one):    Single Middowed   Married   Married   Correction for the continuant Start Date   Correction for the continuant Start Plant   Correction for for the continuant Start Plant   Correction for for for for provider Directory   Correction for			27-0185
Arrive Employee   COBRA Continuous   COBRA Exection Natice of Hours Worked Per Week   Place of Employee	State ZIP	11/Dpp1/ 10/1/0	Sympt Start Date / /
Hours Worked Per Week   Hour	1 A A A A A A A A A A A A A A A A A A A	Active Employee HIPAA Life	Event Configure to support eligibility.)
Hours Worked Per Week   Hour	Single/Widowed ☐ Married	Rehired Employee	or HIPAA CETUIKUSE
Ill-Time Hire for Rehire! Date (Nothing) 2   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013   2013	T C. J	er week	1):10000
Power   Date of Birth (Month/Day/Year)   Age   Product Selections)   Power   Product Selections   Power   Po	ull-Time Hire (or Rehire) Date (Month/Doy/Year):	(Construct)	on 10000
Date of Birth (Month/Day/Year)    Male   Female   Date of Birth (Month/Day/Year)   POR Number from Provider Directory   Are you an Established Patient?	091 15 122 1 1 1 1 Condition	ct Selection(s) PLACK DIA	MOND * SUVision Dental
Male   Female   0.2   1   1   1   1   1   1   1   1   1	Date of Birth (Month/Day/ red)	" Lordort Name: Office	Are you an Established Patient?
Will Name of Physician of Record (POR) Group Practice  First Name    Por Number (If no SSs, write N/A)   Por Number from Provider Directory   Por Number of Spouse/Domestic Partner   Por Number from Provider Directory   Por Number of Spouse/Domestic Partner   Por Number from Provider Directory   Po	1 - 1 00 / 10 / 51 151	R Number from Provider Directory	
I DEPENDENT INFORMATION (If enrolling more than four dependents, please attentions)   II DEPENDENT INFORMATION (If enrolling more than four dependents, please attentions)   II DEPENDENT INFORMATION (If enrolling more than four dependents, please attentions)   II Dependent State   II Stablished Patient   II Stabl			
First Name    Spouse   Spouse	Dr. Molowitz (CottonZ)	the four dependents, pl	ease attach a separate sneed,
First Name    Spouse   Spouse	U DEPENDENT INFORMATION (If enrolling	more than rout	
First Name   Spouse   Domestic Partner	II DELETION		
First Name   Social Security Number (if no SS#, write N/A)   Gender   Male   Female   Date of Birth (Month/Day/Year)   Gender   Male   Gender   Gender	SPOUSE	OMES	Relationship to You?
Social Security Number (If no SS\$, write N/A)  Product Selection(s):  Medical Svision Dental  POR Number from Provider Directory  Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.  Note: If spouse's last name differs from the contract holder above, please attach a Domestic Partner Affidavit and supporting documents to this application.  If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.  Product Selection(s):  Product Selection(s):  Medical Svision Dental  Product Selection(s):  Medical Svision Dental  Product Selection(s):  Medical Svision Dental  POR Number from Provider Directory  Is Child an Established Patient?  Yes No  Step-child Adopted*  Dependent Status if Age 26 or Older  Disabled Act 4**  Product Selection(s):  Medical Svision Dental  POR Number from Provider Directory  Is Child an Established Patient?  Yes No	MI Last Name		
Male   Female   Fem	First Name / F Augus	LCander	Date of Birth (Month/Ddy) real 56 67
Product Selection(s):    Medical	WENDY Of no SS#, write N/A)	Male Female	07721
Medical   Vision   Dental   POR Number from Provider Directory   Ves   No	Social Security Number 115-408		
Medical   Vision   Dental   POR Number from Provider Directory   Ves   No	Partiest Selection(5):		Is Spouse/DP an Established Patients
Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.  Note: If spouse's last name differs from the contract holder above, please attach a Domestic Partner Affidavit and supporting documents to this application.  **If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.  **The property of the pro	Medical Division Dental	POR Number from Provider Directory	
Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.  Note: If spouse's last name differs from the contract holder above, please attach a Domestic Partner Affidavit and supporting documents to this application.  **If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.  **The property of the pro	Full Name of Physician of Record (POR) Group Fraction	04-216	- mi
First Name    Mil	Daisabour Hospital (Dr. 15055110)	please attach a copy of your marriage	e certificate.
First Name    Mil	Manager's last name differs from the contract holder above,	Domestic Partner Affidavit and supp	porting documents to this application.
First Name    Mi	Note: It spouse a large offers Domestic Partner coverage, please attach of	Domesic	
First Name    Step-child   Adopted*   Other*	If your employer one		
First Name    Step-child   Adopted*   Other*			
First Name    Step-child   Adopted*   Other*		DEDENDENT CHILD	
First Name  Social Security Number (If no SS#, write N/A)  Social Security Number (If no SS#, write N/A)  Social Security Number (If no SS#, write N/A)  Product Selection(s);  Medical Avision Dental  For Number from Provider Directory  Social Security Number (If no SS#, write N/A)  Dependent Status if Age 26 or Older  Act 4**  POR Number from Provider Directory  Social Security Number (If no SS#, write N/A)  Social Security Number (If no SS#, write N/A)  Social Security Number (If no SS#, write N/A)  Por Number from Provider Directory  Social Security Number (If no SS#, write N/A)  Dependent Status if Age 26 or Older  Disabled Act 4**  POR Number from Provider Directory  Yes No			Relationship to You? Child
Social Security Number (If no SS\$, write N/A)  Product Selection(s);  Medical Vision Dental  For Number from Provider Directory  Sull Name of Physician of Record (POR) Group Practice  Sull Name of Physician of Record (POR) Group Practice	MI Last Name		Step-child Lindopter
Product Selection(s):    Disabled		Gender	Date of Birth (Month 2007) 1 1998 2
Product Selection(s):    Medical	071	Male LA remaie	Disabled Act 4**
Medical Wision POR Number from Provider Wyes No	Product Selection(s);	2 - Ides Direct	Tanhlished Patient?
Full Name of Physician of Record & CHILDREN HOCPITAL  MILTON CHILDREN HOCPITAL  Accord child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependently	Medical Wision Liberard (POR) Group Practice	POR Number from Provider Direc	
MILTON CHELDICIN TO A child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent	Full Name of Physician of Record (Forgotta)		
advented child or a child that has been legally placed in your care, please attach a copy of the control of the	MILTON CHILDREN TOSTING		over the custodial/legal papers to support depend
	adopted child or a child that has been legally pla	ced in your care, please attach a cop	

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

ENR-129 (814