Employee Enrollment/Change Form – All Plans

To be reviewed and submitted by group administrator. Completed forms should be sent to CoPower within 30 days of change. Missing information could delay processing.

Employer Information

Group Name:		CoPower ID#:
Cordell Network Solutions		905637
Contact Person: Scott Cordell	Contact E-mail: scott@redfireit.com	Contact Phone Number: (909) 266-2661

Member Information

Last Name, First Name:	Social Security Number:	☒ Male ☐ Female	Date of Birth:
Miller, Ryan	530-85-6865		4/9/1992
Street Address:	**City:**	**State:**	**Zip Code:**
157 N Starling Privado	Ontario	CA	91764

Phone Number:	Effective Date (1st of the month only):	**Bundled Plans**
(909) 952-1397	3/1/2023	CoPower *ONE*: ☐ PPO ☐ HMO
Email : ryan@redfireit.com	Date of Hire: 1/31/2022	CoPower *SUITE*: ☐ PPO ☐ HMO

Dental (D)
Delta: ☐ PPO ☒ HMO ☐ Premier
MetLife: ☐ PPO ☐ HMO ☐ *SELECT*
Anthem: ☐ PPO ☐ HMO
UnitedHealthcare: ☐ PPO ☐ HMO
Plan: _____

Vision (V)
☐ Anthem
☒ VSP
☐ MetLife
☐ UnitedHealthcare
Plan: _____

Life (L)
☐ Anthem Life
☐ Anthem Dep. Life
☐ MetLife Life
☐ MetLife LTD
☐ Unum Life
☐ Unum LTD
☐ UnitedHealthcare
Plan: _____
Use Unum voluntary life app for voluntary life plans.

Landmark (LM)
☐ Chiro Only
☐ Chiro + Acu
☐ Acu Only *(51+)*

HMO Dental Office Name *(MetLife HMO does not assign provider)*:	HMO Dental Office ID#:	Life Amount:	Est. Annual Salary *(Round up to 100; LTD only)*:

Reason for Enrollment or Change *(Check one)*

☐ New Hire *(Effective 1st of the month following eligibility period)*
☐ Rehire
☐ Part-time to Full-time
Hire date: _____ Full-time date: _____
☐ Loss of Coverage
(***Required:*** *Proof of loss - a letter from the carrier or employer.)*
☐ Dependent Change
Reason: _____
Qualifying event date: _____

☐ New Group Enrollment
☐ Open Enrollment *(Review group plan contract to verify availability)*
☐ Fed-COBRA Enrollment
Qualifying event date: _____
☐ Name or Social Security Number Change
Previous name or SSN: _____
☐ Member Address Change
☐ Other: _____

Dependents to be Enrolled or Terminated

☐ Enroll ☐ Term.	Spouse/Domestic Partner's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *SUITE* ☐ V ☐ LM	☐ Spouse ☐ Dom. Partner
☐ Enroll ☐ Term.	Child's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *SUITE* ☐ V ☐ LM	☐ Disabled*
☐ Enroll ☐ Term.	Child's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *SUITE* ☐ V ☐ LM	☐ Disabled*
☐ Enroll ☐ Term.	Child's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *SUITE* ☐ V ☐ LM	☐ Disabled*

Dependent child orthodontia age limits vary based on carrier.
**Check only if enrolling a disabled dependent child age 26 & over and if disability occurred prior to limit age.*

Member Signature	**Date:**
Ryan Miller	2/23/2023

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