copower™

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#:
Contact Person:	Contact E-mail:	Contact Phone Number:

Member Information

Last Name, First Name:	Social Security Number:	☐ Male ☐ Female	Date of Birth:
Street Address:	City:	State:	Zip Code:

Phone Number:	Effective Date (1st of the month only):	**Bundled Plans** CoPower *ONE*: ☐ PPO ☐ HMO CoPower *BLUE* ☐ PPO ☐ HMO CoPower *SUITE*: ☐ PPO ☐ HMO
Email :	Date of Hire:	

Dental (D) Delta: ☐ PPO ☐ HMO ☐ Premier MetLife: ☐ PPO Anthem: ☐ PPO ☐ HMO UnitedHealthcare: ☐ PPO ☐ HMO Plan: ___________	**Vision** (V) ☐ Anthem ☐ VSP ☐ UnitedHealthcare Plan: ___________	**Life** (L) ☐ Anthem Life ☐ Anthem Dep. Life ☐ UnitedHealthcare ☐ Unum Life ☐ Unum LTD *Use Unum voluntary life app for voluntary life plans.*	**Landmark** (LM) ☐ Chiro Only ☐ Chiro + Acu ☐ Acu Only *(51+)*
HMO Dental Office Name:	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 ☐ *BLUE* ☐ V ☐ LM ☐ *SUITE*	☐ Spouse ☐ Dom. Partner
☐ Enroll ☐ Term.	Child's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *BLUE* ☐ V ☐ LM ☐ *SUITE*	☐ Disabled*
☐ Enroll ☐ Term.	Child's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *BLUE* ☐ V ☐ LM ☐ *SUITE*	☐ Disabled*
☐ Enroll ☐ Term.	Child's Last Name, First Name:	☐ M ☐ F	DOB:	☐ *ONE* ☐ D ☐ L ☐ *BLUE* ☐ V ☐ LM ☐ *SUITE*	☐ 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:**