Existing Group Enrollment and Change Form

Please complete, sign and date this form.

EMPLOYER INFORMATION

Group Name: CoPower ID:

Contact Person: Contact E-mail:

Contact Phone: ( ) -

EMPLOYEE INFORMATION

First Name: Last Name: Suffix: Gender: ☐ M ☐ F

Date of Birth: / / SSN: - - Date of Hire: / /

Street Address:

City: State: Zip:

Phone Number: ( ) - Effective Date (1st of the month ONLY): / /

Employee E-mail:

REASON FOR ENROLLMENT OR CHANGE (Check One)

☐ New Group Enrollment

☐ Open Enrollment (review group plan contract to verify availability)

☐ New Hire *(Effective 1st of the month following eligibility period)*

☐ Re-hire

☐ Part Time to Full Time Hire Date: / / F/T Date: / /

☐ Loss of Coverage (requires proof of loss of coverage – a letter from carrier or employer)

☐ Fed-COBRA Enrollment: Qualifying Event Date: / /

☐ Name or SSN Change Previous Name or SSN:

☐ Employee Address Change:

☐ Other:

☐ Dependent Change: Reason: Qualifying Event Date: / /

PRODUCT SELECTION(S)

Bundled Plans ☐ CoPower ONE PPO ☐ CoPower ONE HMO ☐ CoPower SUITE PPO ☐ CoPower SUITE HMO

Dental (D)	Delta: ☐ PPO ☐ HMO ☐ Premier MetLife: ☐ PPO ☐ HMO Plan Name:	**HMO ONLY** Office Name: Office ID #: DeltaCare HMO and MetLife HMO do not assign providers
Vision (V)	☐ VSP ☐ MetLife Plan Name:	
Life (L)	☐ Unum Life* ☐ Unum LTD *Use Unum Voluntary Life app for voluntary life plans. ☐ MetLife Life ☐ MetLife LTD ☐ MetLife STD ☐ MetLife (voluntary) Plan Name: Life Amount: $ .00 Est. Annual Salary (Round up to 100) $ .00	
Landmark (LM)	☐ Chiropractic ONLY ☐ Chiropractic + Acupuncture ☐ Acupuncture ONLY	

SPOUSE/DOMESTIC PARTNER TO BE ENROLLED OR TERMINATED:

☐ Enroll ☐ Term Relationship to Employee: ☐ Spouse ☐ Domestic Partner

First Name: Last Name: Suffix

Gender: ☐ Male ☐ Female Date of Birth: / /

Plan Selection(s): ☐ CoPower ONE ☐ CoPower SUITE ☐ Dental ☐ Vision ☐ Life ☐ Landmark

Address (if different):

City: State: Zip:

DEPENDENT CHILD(REN) TO BE ENROLLED OR TERMINATED:

☐ Enroll ☐ Term Relationship to Employee: ☐ Child ☐ Disabled Child

First Name: Last Name: Suffix

Gender: ☐ Male ☐ Female Date of Birth: / /

Plan Selection(s): ☐ CoPower ONE ☐ CoPower SUITE ☐ Dental ☐ Vision ☐ Life ☐ Landmark

Address (if different):

City: State: Zip:

☐ Enroll ☐ Term Relationship to Employee: ☐ Child ☐ Disabled Child

First Name: Last Name: Suffix

Gender: ☐ Male ☐ Female Date of Birth: / /

Plan Selection(s): ☐ CoPower ONE ☐ CoPower SUITE ☐ Dental ☐ Vision ☐ Life ☐ Landmark

Address (if different):

City: State: Zip:

☐ Enroll ☐ Term Relationship to Employee: ☐ Child ☐ Disabled Child

First Name: Last Name: Suffix

Gender: ☐ Male ☐ Female Date of Birth: / /

Plan Selection(s): ☐ CoPower ONE ☐ CoPower SUITE ☐ Dental ☐ Vision ☐ Life ☐ Landmark

Address (if different):

City: State: Zip:

EMPLOYEE SIGNATURE:		**SIGNATURE DATE:**	/ /

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