INSURANCE DESIGN ADMINISTRATORS ENROLLMENT APPLICATION

Clear All Data Entered

Employer Use Only

Group Name

Group ID | EE Code

Effective Date Requested

/ /

Network | Division

Employer's Initials & Date

SECTION 1

Your Last Name First M.I.

Address

City State Zip Code

Your SS No. _____

☐ Single ☐ Married ☐ Divorced

In case of change due to Marriage: In case of change due to Divorce

Date of Marriage _____ Date of Divorce _____

Phone No. _____ Email _____

Employment Status: Active: ☐ Full-time ☐ Part-time ☐ Retired ☐ COBRA

Date of Employment: Date of Retirement:

SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)
☐ Change Coverage to: (check new coverage)
☐ Cancel Coverage: (check those that apply)
☐ Add or Delete Dependent: (complete Section 4)
☐ Change Enrollee's Information: (complete Section 1 with new information)

REASON:

Type	Benefit Selection	Single	Employee/Spouse Employee/Child	Employee/Children or Family	Complement to Medicare

Date of change:

SECTION 3

OTHER COVERAGE? (Inaccurate information may result in claim delay or denial.)
Is there coverage under any other group health plan available to you or any member of your family?
☐ No ☐ Yes, Effective Date

If Yes; Policyholder Name & ID/SS No & Date of Birth. | Relationship ☐ Self ☐ Spouse ☐ Child

Insurance Co. Name & Address | Policy #

Plan Type: ☐ Single ☐ Employee/Spouse ☐ Employee/Child ☐ Employee/Children ☐ Family
Coverage Type: ☐ Medical ☐ Drug ☐ Dental ☐ Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

ADD	DELETE	RELATIONSHIP	DEPENDENT NAME Last First M.I.	Birth Date (mo/day/yr)	Full-time Student	ID/SS No.	Enrolled under Medicare A & B Effective Date
☐	☐	**Self** ☐ M ☐ F		/ /		- -	/ / / /
☐	☐	☐ Employee ☐ Spouse		/ /		- -	/ / / /
☐	☐	☐ Son ☐ Daughter		/ /	☐ Yes ☐ No	- -	/ / / /
☐	☐	☐ Son ☐ Daughter		/ /	☐ Yes ☐ No	- -	/ / / /
☐	☐	☐ Son ☐ Daughter		/ /	☐ Yes ☐ No	- -	/ / / /

Do(es) your Dependent Child(ren) reside in your home?
☐ Yes ☐ No If No, give address:

Dependent(s) exceeding initial limiting age of 26: (Must provide proper documentation to support status for enrollment)
List Name(s):

Do you have a Disabled Dependent beyond 26 years of age?
☐ Yes ☐ No Enrolled under Medicare? ☐ Yes ☐ No

List Name(s):

WAVIER OF COVERAGE:

☐ I have elected to Waive Employee and Dependent Coverage ☐ I have elected to Waive Coverage for my ☐ Spouse and/or ☐ Dependent Child(ren).

Please state the reason for Waiving Coverage and list your coverage that is currently effective. Proof and Copy of ID Card are required.

Applicant's/ Authorized Representative'signature _____ Date

Please save and print a copy for your files then email a copy to your employer to review and email to IDA

SAVE AS

PRINT