# Smith County

## Enrollment Form

Location: _____ Social Security #: _____

Effective Date: _____ Section 125: ❑ Yes ❑ No

Employee Name: _____ Sex: Male ❑ Female ❑

Address: _____ DOB: _____ Annual Salary _____

City _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Hire: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Surviving Spouse

### MEDICAL/DENTAL/VISION

**Do you use any type of tobacco product? ❑ Yes ❑ No**

**Medical Coverage Requested: ❑ Yes ❑ No**

**❑ Plan 1 ❑ Plan 2 ❑ Plan 3**

**Dental Coverage Requested: ❑ Yes ❑ No**

**Vision Coverage Requested: ❑ Yes ❑ No**

**Check the coverage needed for each dependent:**

M = Medical
D= Dental
V=Vision

**List All Dependents To Be Included For Coverage**

| First Name | Initial | Last Name | Relationship | Sex | Social Security # | Date of Birth | M | D | V |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | ❑ | ❑ | ❑ |
| | | | | | | | ❑ | ❑ | ❑ |
| | | | | | | | ❑ | ❑ | ❑ |
| | | | | | | | ❑ | ❑ | ❑ |
| | | | | | | | ❑ | ❑ | ❑ |
| | | | | | | | ❑ | ❑ | ❑ |

**ARE ANY OF YOUR DEPENDENTS COVERED BY A QUALIFIED MEDICAL CHILD SUPPORT ORDER?** ❑ Yes ❑ No

**(IF YES COMPLETE INFORMATION BELOW)**

| | | | |
|---|---|---|---|
| Custodial Parent: | | Custodial Parent: | |
| Name of Dependent: | | Name of Dependent: | |
| Residential Address: | | Residential Address: | |

**Are you or any of your covered dependents covered by any other Health or Dental Insurance?**

**❑ Yes ❑ No**

If Yes:

| Policy or Group # | Name of Insurance | Who is covered under this Plan? | Medical or Dental |
|---|---|---|---|
| | | | |
| | | | |

Employees Signature _____ Date _____ Employee # _____

Employers Signature _____ Date _____ Department _____

To be completed by TPA:

Date Entered/Initials _____ Dated Ordered ID Card _____ Date Requested HIPAA _____

## You Must State Your Beneficiaries

| Name | Address | Relationship | Percent of Benefit | |
|---|---|---|---|---|
| | | | | Primary ❑ Secondary ❑ |
| | | | | Primary ❑ Secondary ❑ |
| | | | | Primary ❑ Secondary ❑ |
| | | | | Primary ❑ Secondary ❑ |