

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:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:		City:	State: _____ Zip Code: _____
Phone Number:	Effective Date (1 st of the month only):		Bundled Plans CoPower ONE: <input type="checkbox"/> PPO <input type="checkbox"/> HMO CoPower SUITE: <input type="checkbox"/> PPO <input type="checkbox"/> HMO
Email :	Date of Hire:		
Dental (D) Delta: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Premier MetLife: <input type="checkbox"/> PPO <input type="checkbox"/> HMO Anthem: <input type="checkbox"/> PPO <input type="checkbox"/> HMO Plan: _____	Vision (V) <input type="checkbox"/> Anthem <input type="checkbox"/> VSP <input type="checkbox"/> MetLife Plan: _____	Life (L) <input type="checkbox"/> Anthem Life <input type="checkbox"/> Anthem Dep. Life <input type="checkbox"/> MetLife Life <input type="checkbox"/> MetLife LTD <input type="checkbox"/> MetLife Life (Voluntary) <input type="checkbox"/> Unum Life <input type="checkbox"/> Unum LTD Plan: _____ <small>Use Unum voluntary life app for voluntary life plans.</small>	Landmark (LM) <input type="checkbox"/> Chiro Only <input type="checkbox"/> Chiro + Acu <input type="checkbox"/> Acu Only (51+)
HMO Dental Office Name <i>(MetLife HMO does not assign provider):</i>	HMO Dental Office ID#:	Life Amount:	Est. Annual Salary (Round up to 100; LTD only):

Reason for Enrollment or Change (Check one)	
<input type="checkbox"/> New Hire (Effective 1 st of the month following eligibility period) <input type="checkbox"/> Rehire <input type="checkbox"/> Part-time to Full-time Hire date: _____ Full-time date: _____ <input type="checkbox"/> Loss of Coverage <i>(Required: Proof of loss - a letter from the carrier or employer.)</i> <input type="checkbox"/> Dependent Change Reason: _____ Qualifying event date: _____	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Open Enrollment (Review group plan contract to verify availability) <input type="checkbox"/> Fed-COBRA Enrollment Qualifying event date: _____ <input type="checkbox"/> Name or Social Security Number Change Previous name or SSN: _____ <input type="checkbox"/> Member Address Change <input type="checkbox"/> Other: _____

Dependents to be Enrolled or Terminated					
<input type="checkbox"/> Enroll <input type="checkbox"/> Term.	Spouse/Domestic Partner's Last Name, First Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	<input type="checkbox"/> ONE <input type="checkbox"/> D <input type="checkbox"/> L <input type="checkbox"/> SUITE <input type="checkbox"/> V <input type="checkbox"/> C/A	<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Partner
<input type="checkbox"/> Enroll <input type="checkbox"/> Term.	Child's Last Name, First Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	<input type="checkbox"/> ONE <input type="checkbox"/> D <input type="checkbox"/> L <input type="checkbox"/> SUITE <input type="checkbox"/> V <input type="checkbox"/> C/A	<input type="checkbox"/> Disabled*
<input type="checkbox"/> Enroll <input type="checkbox"/> Term.	Child's Last Name, First Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	<input type="checkbox"/> ONE <input type="checkbox"/> D <input type="checkbox"/> L <input type="checkbox"/> SUITE <input type="checkbox"/> V <input type="checkbox"/> C/A	<input type="checkbox"/> Disabled*
<input type="checkbox"/> Enroll <input type="checkbox"/> Term.	Child's Last Name, First Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	<input type="checkbox"/> ONE <input type="checkbox"/> D <input type="checkbox"/> L <input type="checkbox"/> SUITE <input type="checkbox"/> V <input type="checkbox"/> C/A	<input type="checkbox"/> Disabled*

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

Member Signature	Date: