New Group Enrollment & Waiver Form

Please complete, sign and date this form.

CO power
An Amwins Company

EMPLOYER INFORMATION

Group Name: CoPower ID:

Contact Person: Contact E-mail:

Contact Phone: - -

EMPLOYEE INFORMATION

Last Name: First Name: Gender: ☐ Male ☐ Female

SSN: - - Date of Birth: / /

Street Address:

City: State: Zip:

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

E-mail: Date of Hire: / /

COBRA: ☐ Dental: ☐ Vision: Qualifying Event:

Qualifying Event Date: / / Initial Effective Date: / /

PRODUCT SELECTION

Bundled Plans: ☐ CoPower One PPO ☐ CoPower One DHMO

Dental Selection: ☐ Delta Dental PPO ☐ Delta Dental DHMO

Dental Plan Name:

HMO Dental ONLY: Dental Office Name: Dental Office ID Number:

☐ VSP Selection Vision Plan Name:

Life Plan Selection: ☐ Unum Life and Accidental Death & Dismemberment* ☐ Unum Long Term Disability

Life Plan Name: Life Amount: $ Est. Annual Salary: $
(Round up to 100k; LTD ONLY)

Use Unum voluntary life application for voluntary life plans.

Landmark: ☐ Chiropractic ONLY ☐ Acupuncture ONLY ☐ Chiropractic AND Acupuncture

SPOUSE / DOMESTIC PARTNER TO BE ENROLLED

Last Name: First Name: MI: Suffix:

Address, if different from Employee: Gender: ☐ Male ☐ Female

City: State: Zip:

Date of Birth: / / Relationship to Employee: ☐ Spouse ☐ Domestic Partner

Plan Selection(s): ☐ CoPower One ☐ Dental ☐ Vision ☐ Life ☑ Landmark

DEPENDENT CHILDREN TO BE ENROLLED

Last Name: First Name: MI: Suffix:

Address, if different from Employee: Gender: ☐ Male ☐ Female

City: State: Zip:

Date of Birth: / / Relationship to Employee: ☐ Child ☐ Disabled Child

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

Last Name: First Name: MI: Suffix:

Address, if different from Employee: Gender: ☐ Male ☐ Female

City: State: Zip:

Date of Birth: / / Relationship to Employee: ☐ Child ☐ Disabled Child

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

Last Name: First Name: MI: Suffix:

Address, if different from Employee: Gender: ☐ Male ☐ Female

City: State: Zip:

Date of Birth: / / Relationship to Employee: ☐ Child ☐ Disabled Child

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

Last Name: First Name: MI: Suffix:

Address, if different from Employee: Gender: ☐ Male ☐ Female

City: State: Zip:

Date of Birth: / / Relationship to Employee: ☐ Child ☐ Disabled Child

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

EMPLOYEE COVERAGE WAIVED

☐ Dental Waived: Other dental coverage. Carrier Name: ID Group No:

☐ Dental Declined: I do not have other dental coverage decline to enroll.

☐ Vision Waived: Other vision coverage. Carrier Name: ID Group No:

Eligible employees may refuse vision coverage if they are covered by another vision program.

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