

SPECIAL ENROLLMENT VERIFICATION

NAME OF EMPLOYEE: _____

SOCIAL SECURITY NUMBER: _____

1. I am applying for coverage for:
- myself only
 - myself and my eligible dependents *
 - my eligible dependents only *

*I understand that these dependents must meet the criteria of an eligible dependent(s) under the terms of the group health plan for which I am applying for coverage. Refer to “Who May Be A Dependent” in your SPD.

because of loss of other **Medical** coverage under a:

- Group Health Plan
- Health Insurance Coverage

2. The reason for loss of other **Medical** coverage is:
- Termination of Employment
 - Reduction In The Number of Hours Of Employment
 - Legal Separation
 - Divorce
 - Death
 - Employer contributions toward such coverage were terminated.

3. The **date of loss** of other **Medical** coverage is _____ and this termination date applies to the following individuals:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

This is _____ **day of** _____ **20**_____.

I understand that if I and/or my eligible dependents are approved for coverage, the effective date of coverage will be assigned as outlined in the Summary Plan Description under the “Special Enrollment Provisions”.

Employee’s Signature

Employer: _____

Witness: _____ **(Employer Representative)**