BENEFITS DESIGN GROUP
ENROLLMENT APPLICATION / CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION

Last Name	First Name	Middle

Social Security Number	Date of Birth	Email	Telephone

Mailing Address	City	State	Zip Code

SECTION 2 – DEPENDENT INFORMATION *(list only if covered by your health plan)*

Dependent's Last Name	First Name	Relationship: ☐ Spouse ☐ Child
Date of Birth	**Social Security Number**	**Home Address, if different**

Dependent's Last Name	First Name	Relationship: ☐ Spouse ☐ Child
Date of Birth	**Social Security Number**	**Home Address, if different**

Dependent's Last Name	First Name	Relationship: ☐ Spouse ☐ Child
Date of Birth	**Social Security Number**	**Home Address, if different**

Dependent's Last Name	First Name	Relationship: ☐ Spouse ☐ Child
Date of Birth	**Social Security Number**	**Home Address, if different**

Dependent's Last Name	First Name	Relationship: ☐ Spouse ☐ Child
Date of Birth	**Social Security Number**	**Home Address, if different**

SECTION 3 – PLAN SELECTION

Enrollees	Plan Selection
☐ Employee Only ☐ Employee + Spouse	☐ Plan 1
☐ Employee + Child(ren) ☐ Employee + Family	☐ Plan 2
	☐ Plan 3

Employee Signature ______________________________ **Date** ______________

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