90 DEGREE BENEFITS
A Turn For The Better

ENROLLMENT/CHANGE FORM

Employer:	Group #	Dept:	Plan:
TULSA FIREFIGHTERS	**M8086**	☐ **Active** ☐ **Retiree**	☐ **HDHP** ☐ **Traditional**

Name of Employee (Last, First, MI) (Please Print)				Social Security Number
Mailing Address	City	State	Zip Code	Home Phone #

☐ Male ☐Female	Employee Birth Date / /	Date of Hire/Rehire / /	Effective Date / /

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

COVERAGE INFORMATION

Medical Coverage Elected: ☐ **Employee Only** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Family**

☐ Add dependents – check event and give date (List dependents below)
☐ Marriage–Date: _____ ☐ Birth or ☐Adoption Date:_____
☐ Remove dependents – check event and give date.
☐ Divorce-Date of Decree: _____ ☐ Death-Date: _____
☐ Other Ineligible – Specify: _____
☐ Change Medical/Dental Coverage to: ☐ Employee Only ☐ Employee & Family

☐ Change name to that shown above. My former name was: _____
☐ Does this name change affect other covered dependents?
☐ If so, specify: _____
☐ Change address to that shown above.
☐ Change Beneficiary to that shown above.
☐ Other _____

DEPENDENT/RELATIONSHIP INFORMATION

LIST ONLY COVERED DEPENDENTS - INDICATE RELATIONSHIP OF EACH DEPENDENT

S=SPOUSE/C=COMMON LAW SPOUSE/N=NATURAL CHILD/T=STEP CHILD/F=FOSTER CHILD/G=GRAND CHILD/A=ADOPTED CHILD /O=OTHER (MUST SPECIFY)

LAST, FIRST, MI	REL CODE	Social Security Number	Birthdate MM/DD/YR	Sex M	Sex F	Spouse's Employer/Phone #
Spouse						
Child						
Child						
Child						
Child						

Do you or your dependents have other coverage? ☐ YES ☐ NO If yes, list who is covered?
_____
Type of Coverage: _____Medical _____ Dental Name/Phone Number of carrier:

Acceptance of Coverage

I am enrolling under my employer's health benefit plan for the coverage elected above.

Signature_____ **Date** _____

Declining Coverage - Active Member

If you are declining enrollment for your dependents because of other health insurance coverage, you may in the future be able to enroll those dependents in this plan, provided you request enrollment within 30 days after the other coverage ends. To qualify for this special enrollment period, the dependent(s) must have lost the other coverage because either COBRA is now exhausted or non-COBRA coverage terminated due to loss of eligibility for coverage or because employer contributions for the coverage were terminated. I understand the above statement and wish to waive health coverage for my dependents.

If you have refused dependent coverage, is it because your dependents have other coverage? ☐ YES ☐ NO

Signature _____ **Date** _____

Declining Coverage - Retiree

I wish to waive health coverage for myself and/or my dependents. I understand that I will not be able to re-enroll in the future.

Signature _____ **Date** _____