Smith County

Enrollment Form

Location: _____ Social Security #: _____

Effective Date: _____ Section 125: ❑ Yes ❑ No

Employee Name: _____ Sex: Male ❑ Female ❑

Address: _____ DOB: _____ Annual Salary _____

City _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Hire: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Surviving Spouse

MEDICAL/DENTAL/VISION

Do you use any type of tobacco product? ❑ **Yes** ❑ **No**

Medical Coverage Requested: ❑ **Yes** ❑ **No**

❑ **Plan 1** ❑ **Plan 2** ❑ **Plan 3** ❑ **Plan 4**

Dental Coverage Requested: ❑ **Yes** ❑ **No**

Vision Coverage Requested: ❑ **Yes** ❑ **No**

Check the coverage needed for each dependent:

M = Medical
D= Dental
V=Vision

List All Dependents To Be Included For Coverage

First Name	Initial	Last Name	Relationship	Sex	Social Security #	Date of Birth	M	D	V
							❑	❑	❑
							❑	❑	❑
							❑	❑	❑
							❑	❑	❑
							❑	❑	❑
							❑	❑	❑

ARE ANY OF YOUR DEPENDENTS COVERED BY A QUALIFIED MEDICAL CHILD SUPPORT ORDER? ❑ Yes ❑ No

(IF YES COMPLETE INFORMATION BELOW)

Custodial Parent:		Custodial Parent:	
Name of Dependent:		Name of Dependent:	
Residential Address:		Residential Address:	

Are you or any of your covered dependents covered by any other Health or Dental Insurance?

❑ **Yes** ❑ **No**

If Yes:

Policy or Group #	Name of Insurance	Who is covered under this Plan?	Medical or Dental

Employees Signature _____ Date _____ Employee # _____

Employers Signature _____ Date _____ Department _____

To be completed by TPA:

Date Entered/Initials _____ Dated Ordered ID Card _____ Date Requested HIPAA _____

You Must State Your Beneficiaries

Name	Address	Relationship	Percent of Benefit	
				Primary ❑ Secondary ❑
				Primary ❑ Secondary ❑
				Primary ❑ Secondary ❑
				Primary ❑ Secondary ❑