



# City of Memphis ENROLLMENT / ACTIVE CHANGE FORM

# 2012

Note: Only complete if you wish to change plans, add or delete dependents or currently do not have City health coverage and elect to enroll in a plan.

EMPLOYEE INFORMATION			APPLYING FOR (COMPLETE ALL THAT APPLIES)			EMPLOYER USE ONLY	
Employee Name (Last Name, First Name, Middle Initial)		List PCP ID Number	<input type="checkbox"/> PRE TAX	<input type="checkbox"/> POST TAX		EFFECTIVE DATE EMPLOYEE / /	
Social Security Number	Sex (M or F)	Date of Birth - MM/DD/YY	<input type="checkbox"/> CITY OF MEMPHIS BASIC			EFFECTIVE DATE DEPENDENT(S) / /	
Street Address			<input type="checkbox"/> CITY OF MEMPHIS PREMIER			TERMINATION DATE / /	
City	State	Zip	<input type="checkbox"/> ENROLL	<input type="checkbox"/> DELETE	<input type="checkbox"/> CANCEL	DIVISION CODE	
Daytime Phone Number ( )		Evening Phone Number ( )	<input type="checkbox"/> Waive Coverage			ENTERED BY	
Division	E-Mail Address		YOUR PLAN WILL COVER			HIRE DATE: / /	
			<input type="checkbox"/> FAMILY	<input type="checkbox"/> SINGLE		EMPLOYMENT STATUS ACTIVE COBRA NEMP	

List all dependents you wish to ADD TO YOUR COVERAGE or DELETE FROM YOUR COVERAGE or UPDATE SOCIAL SECURITY NUMBER on your coverage

Last Name	First Name	Initial	Social Security Number	Date of Birth (MM/DD/YY)	Sex (M or F)	Full Time Student (YES / NO)	For Premier ONLY (List PCP ID Number)
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

If you or your dependents are covered by other group insurance, please fill out the following information:

Name of Person covered by other insurance	Social Security Number	Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: Effective <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	Date / /
Name of Company this Person works for	Group No.	Medicare HICN: Name: Relationship:		
Name of other Insurance Company	Effective Date:	Comments:		
List dependents Covered:				

By signing below, I certify that: the information provided above is true and correct. I accept the plan rules as set forth by the City of Memphis; and I authorize payroll deduction for the plan above.

Form must be completed and signed by City employee to be accepted.	NOTARY SIGNATURE	NOTARY EXPIRATION DATE
Retiree's Signature Date		