

**q3/Headwaters Benefit Plan Enrollment Form** (please print in ink or type)

Employer	Plan	Soc Sec #
Name (First, MI, Last)	Date of Birth	Gender (M/F)
Home Address (incl. Zip Code)		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced		County
Email		Phone

**Employer Section** (to be completed or verified by employer)

<input type="checkbox"/> Open Enrollment (original effective date _____)	<input type="checkbox"/> Late Enrollment
<input type="checkbox"/> Initial Enrollment (date employed full-time _____)	<input type="checkbox"/> Change Coverage/Information
<input type="checkbox"/> Rehire (date re-employed full-time _____)	<input type="checkbox"/> Termination/Reduction of Hours (date _____)
<input type="checkbox"/> COBRA Election (date of election _____)	<input type="checkbox"/> Layoff (date _____)
<input type="checkbox"/> Special Enrollment - <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Child placed for Adoption <input type="checkbox"/> Loss of other coverage* Event Date _____ Attach documentation (*include proof of other coverage when this coverage was earlier declined)	
Earnings \$ _____ <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly	Class

**Dependent Information** (list all dependents to be covered)

Relationship	Name (First, MI, Last)	Gender (M/F)	Date of Birth
Spouse			
Child			
Child			
Child			
Child			
Child			
Child			
Child			

Are all of the children listed above natural children, stepchildren, or legally adopted children?  Yes  No  N/A

**Coverage(s) Desired** (do not check more than one block in each column)

To be covered	Medical	Dental	Vision	
NONE (Waive all coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee ONLY (Single coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee & Spouse ONLY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee & Children ONLY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee & All Dependents (Family coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Plan/PPO Choice (if allowed)

Do any family members to be covered intend to keep coverage under any other Group or Insurance Plan (including employer provided coverage, private insurance, student insurance, COBRA, Medicare and Medicaid)?  Yes  No

Are you or any of your dependents disabled, facility confined, or pregnant?  Yes\*  No  
 \* If yes, please give name(s)/details -

Beneficiary Name, Address, Relationship

I declare that the above information is correct and true. I authorize payroll deduction from my earnings for any contribution I am required to make. I acknowledge receipt of "q3 Required Notices (6/01)". I understand that coverage may be denied later if I or my dependents decline coverage or do not apply when first eligible.

Signature	Date
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