



# Employee enrollment and change form

**EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.**

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number:**

1. Spouse Medicare claim # \_\_\_\_\_ 2. Dependent name \_\_\_\_\_ 3. Medicare claim # \_\_\_\_\_

## **Additional health benefits information**

Other insurance (that is not Group Health Cooperative or Group Health Options, Inc.) \_\_\_\_\_

Who is the subscriber under this plan? \_\_\_\_\_

What is their social security or policy number with this plan? \_\_\_\_\_ Attach any certificate of creditable coverage letters to this form.

\_\_\_\_\_  
**(Signature of employee)**

\_\_\_\_\_  
**(Date signed)**

Please retain a copy for your records.