

FLAGSTAFFSM

DENTAL/VISION/LIFE ENROLLMENT FORM

Requested Effective Date _____ New App _____ Status Change _____

| | | | | | | |
|---------------------------|---------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------|--|
| Client Name _____ | | | Original Hire Date _____ | Social Security Number _____ | | Sex M <input type="checkbox"/> F <input type="checkbox"/> |
| Employee Name: Last _____ | First _____ | M. I. _____ | Occupation _____ | Date of Birth _____ | Height _____ | Weight _____ |
| Street Address _____ | | | City _____ | State _____ | Zip _____ | Telephone # _____ |
| Coverage Applying For → | Dental <input type="checkbox"/> | Vision <input type="checkbox"/> | Life Only <input type="checkbox"/> | Dependent Status → | Single <input type="checkbox"/> | Family 2+ <input type="checkbox"/> |

| Dependent Name | Relationship | Date of Birth | Social Security # | | |
|----------------|--------------|---------------|-------------------|--|--|
| 1. | Spouse | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

| | | |
|---------------------|--------------------|------|
| X | -- | -- |
| Applicant Signature | City, State Signed | Date |

| | |
|----------------------------|---------------------|
| Life Insurance Beneficiary | Relationship to You |
|----------------------------|---------------------|