



National Academy of Sciences Enrollment Application (Medical and Dental)

PLEASE READ INSTRUCTIONS BELOW.

Section 1

ASSOCIATE INFORMATION						
LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married
HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER		
SPONSOR NAME National Academy of Sciences	WORK PHONE NUMBER					

Section 2

MEDICAL AND DENTAL COVERAGE
<p><input type="checkbox"/> Associate Only</p> <p><input type="checkbox"/> Associate Plus One</p> <p><input type="checkbox"/> Associate Plus Family</p> <p><input type="checkbox"/> I decline coverage.</p> <p><i>Reason:</i></p> <p><input type="checkbox"/> Covered under another plan.</p> <p><input type="checkbox"/> Other: _____</p> <p><i>*Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered late enrollees if you enroll in this plan at a later date.</i></p>



Section 3

COVERAGE INFORMATION								
	(A) Add (T) Term (C) Chg	Last Name	First Name	MI	DOB (MM/DD/YYYY)	Sex	Social Security Number	Handicapped?
Associate						<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse /Partner						<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
Child - 1						<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
Child - 2						<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
Child - 3						<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N
Child - 4						<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N

Section 4

OTHER INSURANCE			
- On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, Medicare or Medicaid? <input type="checkbox"/> Y <input type="checkbox"/> N			
- Is another person legally responsible for coverage for your children? <input type="checkbox"/> Y <input type="checkbox"/> N			
- If you answered yes to either of the questions above, please complete the following			
Person's Name with Other Health Plan		Social Security Number	
Date of Birth	Sex	Other Company's Name and Phone Number	
Other Company's Policy Number		Other Policy Effective Date	
Medicare Number	Part A Effective Date	Part B Effective Date	



Enrollment Application and Change Form Instructions

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 Complete all information.

SECTION 2 Check the coverage tier you would like and who should be covered

SECTION 3 Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan.

T = To terminate yourself or a dependent's coverage.

C = To change information about yourself or a dependent.

Print your full name and the names of your covered dependents, if any. Check which type of coverage you will be enrolling yourself and your dependents in. Provide the date of birth, sex and social security number for each dependent and check the appropriate boxes indicating if a dependent is handicapped. (If you have more than 5 dependents, please attach an additional enrollment form.)

SECTION 4 This section must be completed for all new enrollments or coverage changes.

SECTION 5 The Associate must sign and date this form in order for it to be processed.

SECTION 6 This section is to be completed by the National Academy of Sciences's benefit representative.