Advantek Benefit Administrators
P O Box 45007
Fresno, CA 93718

HEALTH INSURANCE ENROLLMENT FORM

Group Name:

Date of Hire: **Effective Date**

ENROLLEE (complete this section for new enrollment or change of status)

Name Last_____ First _____ Initial____ **Mailing Address** Street _____ City _____ State _____ Zip code_____ Date of Birth: _____Telephone Number: _____	**Do you have dependent children?** Yes __ No__ **Martial Status** __Single __Married __Divorced __Separated	**Social Security #** **Employee Number** **Male __ Female __**	**Action Required** **__New enrollment** **__COBRA enrollment** **__Change in enrollment** **__Rehire** **__Reinstatement** **__Transfer**

CHANGE TO EXISTING ENROLLMENT (complete all section that apply)

___Name Change __Add new dependent __ Delete dependent __ Address change listed above
Reason for change _____

DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Relation to Employee	Last Name	First Name	Middle Initial	Date of Birth	M or F	Social Security

Is there other coverage in effect for yourself or covered dependents? Yes___ No___ If so, complete the following information:
Name & Phone # of Insurance Company: _____
Is coverage through spouse's employer? _____ Yes _____No
If yes, name of Employer: _____ Group No. _____
Address of Spouse's Employer: _____

Employee Signature: _____ Date: _____