NORTH AMERICA ADMINISTRATORS, L.P. ENROLLMENT FORM

naa | North America Administrators

Employer _____ ○ Full-Time ○ Retiree

Department_____ Class: _____ ○ COBRA ○ Reinstatement of Coverage

○ Hourly ○ Salaried ○ Union

EMPLOYEE INFORMATION

Employee Name: Last	First	Middle Initial	Social Security Number	Sex ○ M ○ F	Date of Birth (Mo./Day/Yr.)

Email Address		
Street Address		Home Phone # ( )
City		
State	Zip	County

MARITAL STATUS
○ Single
○ Married

APPLY FOR:
○ Self
○ Self & Spouse
○ Self & Children
○ Self & Family

COVERAGE ELECTIONS
○ Standard Medical
○ Dental
○ Vision
○ Life
○ Dependent Life
○ Supplemental Life
○ Disability Income
○ LTD

VOLUME

HIRE DATE _____

EFFECTIVE DATE _____

REMARKS _____

OFFICE USE ONLY

PROCESSED DATE _____

USER I.D. _____

Name of Beneficiary: Last	First	Middle Initial	Relationship

USE THE SPACE BELOW TO LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER. <u>Last name required if different from employee's.</u> If any dependent has a different address please note dependent number (i.e., #1, 2, 3, etc.) and address on back of form.

1. Spouse's Name	Date of Birth (Mo./Day/Yr.)	Sex ○ M ○ F	Social Security Number	
2. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ○ M ○ F	Social Security Number	Relationship ○ Natural Child ○ Stepchild ○ Other
3. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ○ M ○ F	Social Security Number	Relationship ○ Natural Child ○ Stepchild ○ Other
4. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ○ M ○ F	Social Security Number	Relationship ○ Natural Child ○ Stepchild ○ Other
5. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ○ M ○ F	Social Security Number	Relationship ○ Natural Child ○ Stepchild ○ Other
6. Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ○ M ○ F	Social Security Number	Relationship ○ Natural Child ○ Stepchild ○ Other

OTHER INSURANCE INFORMATION

Are you or any of your dependents covered by other insurance? ○ Yes ○ No

If yes, you must fill out the following information to qualify at any time as a Special Enrollee. (Attach separate sheet if additional space is required.)

Name of Person Covered by Other Insurance	Social Security Number
Name of Other Employer	Group No.
Name of Other Insurance Company	
Address of Other Insurance Company	

○ I hereby apply for the coverage to which I am now entitled or to which I may become entitled under the provisions of the Group Plan or Plans issued through North America Administrators, LP. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage by my employer.

○ I acknowledge that I have been given the opportunity to elect coverage under the group benefit plans and hereby decline coverage for the following: _____

_____

I decline coverage because: _____

_____

(YOU <u>MUST COMPLETE</u> *"OTHER INSURANCE INFORMATION"* IF APPLICABLE)

I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish North America Administrators, L.P. with full information regarding medical treatment (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish North America Administrators, L.P. with information regarding benefits to which I may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

EMPLOYEE SIGNATURE _____ DATE_____