Community Health Plan of the Siskiyous
For your quality of life

City of Yreka - 3004
ENROLLMENT/CHANGE FORM

INSTRUCTIONS:

Please complete & sign this form. Print legibly & read all questions carefully – incomplete information will delay enrollment.

Date of Hire (Full-Time):	Coverage Effective Date:	**Type of Action**
		☐ New Enrollment ☐ COBRA Enrollment ☐ Tier Change ☐ Address Change ☐ Other _____
COBRA-Last Day Worked:	**Termination Date:**	

PARTICIPANT INFORMATION:

Name – Last	First	MI
Street Address		
City	**State**	**Zip**	**Home Phone#**

Date of Birth	Sex	SSN#	Marital Status
	☐ Male ☐ Female		☐ Single ☐ Married ☐ Divorced

DEPENDENT INFORMATION:

☐ No, I DO NOT wish to enroll my dependents

☐ Yes, I wish to enroll the following dependents for coverage:

RELATIONSHIP	FULL NAME	SEX	BIRTHDATE	SOCIAL SECURITY #
Spouse		☐ Male ☐ Female		
Child		☐ Male ☐ Female		
Child		☐ Male ☐ Female		
Child		☐ Male ☐ Female		

For additional dependents, please attach additional enrollment form.

ABOUT YOUR OTHER HEALTH INSURANCE :

Do you or any of your dependents have any other health or dental coverage? ☐ Yes ☐ No If yes complete Section below:

Name of Policy Holder	Name & Address of other insurance	Policy number	Effective Date	Coverage Type- Medical or Dental

I UNDERSTAND that if I do not elect coverage for myself, or fail to enroll any existing dependents at this time, enrollment of myself or such dependents at a later date can only occur at such time satisfactory to the administrator of the plan or during an annual open enrollment period, if applicable.

By accepting enrollment in this group insurance plan, I authorize my employer to deduct from my earnings the contributions, IF ANY, required for coverage. To the best of my knowledge, all of the above information is correct.

Signature_____ Date Signed_____

(REV 1/04)