



R H ADMINISTRATORS, INC.

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ENROLLMENT FORM

EMPLOYERS NAME _____ GROUP NUMBER _____ DIVISION _____

EMPLOYEES FIRST NAME _____ MI _____ LAST NAME _____ Male Female

HOME PHONE _____

ADDRESS -- NAME, NUMBER & STREET _____ APT# _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ DATE OF EMPLOYMENT _____ EFFECTIVE DATE _____

BENEFICIARY NAME _____ RELATIONSHIP _____

ANNUAL SALARY/LIFE AMOUNT _____

OTHER GROUP INSURANCE COVERAGE

SOCIAL SECURITY NUMBER (For Employee Only) _____

NAME OF SPOUSES EMPLOYER _____

COVERAGE INFORMATION

- | | | | | |
|----------------------------|--|--|--|---------------------------------|
| MEDICAL COVERAGE ELECTIONS | <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE & SPOUSE | <input type="checkbox"/> EMPLOYEE/CHILD(REN) | <input type="checkbox"/> FAMILY |
| DENTAL COVERAGE ELECTIONS | <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE & SPOUSE | <input type="checkbox"/> EMPLOYEE/CHILD(REN) | <input type="checkbox"/> FAMILY |
| VISION COVERAGE ELECTIONS | <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE & SPOUSE | <input type="checkbox"/> EMPLOYEE/CHILD(REN) | <input type="checkbox"/> FAMILY |

IF SPOUSE OR DEPENDENT COVERAGE IS ELECTED, PLEASE LIST BELOW

FIRST NAME	MI	LAST NAME	MALE	FEMALE	DOB	EFFECTIVE DATE	FT STUDENT	SOCIAL SECURITY #	DISABLED
							YES NO		YES NO
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>

Are you or any other family member listed above eligible/covered by any other insurances? Yes No

PAYROLL AUTHORIZATION

I hereby request my employer to arrange for the issuance of the insurance to which I am now entitled, or to which I may become entitled, under the terms of the group Policy or Policies issued to my employer, and I authorize my employer to make the proper deductions (if any) from my earnings as my contribution toward the cost of this insurance.

DATE SIGNED _____

SIGNATURE OF EMPLOYEE _____

WAIVER OF EMPLOYEE GROUP COVERAGE

EMPLOYER NAME _____

I have been given an opportunity to apply for group coverage offered by my employer, I understand the benefits available, and I decline:

- MEDICAL COVERAGE DENTAL COVERAGE VISION COVERAGE ALL COVERAGE

The reason my my declination is: Coverage under my spouse's plan Other

I understand that if I decline coverage now, I may not enroll for coverage until the next open enrollment period (if my employer offers), unless I experience a qualifying family status change event.

SIGNATURE _____

DATE _____