CLARK ATLANTA UNIVERSITY
APPLICATION FOR ENROLLMENT

GROUP # _____*L01226*_____

EMPLOYER USE ONLY: ☐ NEW ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE ☐ TERMINATION

TEAM MEMBER INFORMATION

Complete the following information below:

Name: (Last) _____ (First) _____ (Maiden/Middle Name) _____
Suffix: (Junior, Senior) _____ Social Security Number: ____-___-____ Gender: ○Male ○Female
Date of Birth: (mm/dd/yyyy) __ /__ /____ CAU Employee ID Number: _____

Mailing Address:_____
City: _____ State: _____ ZIP: _____
Email: _____ Phone Number: (___) ___-____ ○Home ○Work ○Cell

Marital Status: (Mark One) ○Single ○Married ○Divorced ○Widowed

HEALTH PLAN (MEDICAL/PRESCRIPTION/DENTAL/VISION): ANTHEM

○ **Select the Plan you wish to enroll in:** ☐ Plan A ☐ Plan B ☐ Waive
○ **Select your requested Coverage Tier:** ☐ EE Only ☐ EE+SP ☐ EE+CH ☐ Family

***Note:** **List all Dependent(s) you are enrolling in the Health Plan <u>in the Dependent Section on Page 2</u>.**

☐ I REFUSE ALL MEDICAL/PRESCRIPTION DRUG/DENTAL/VISION COVERAGE (I understand that I will not be permitted to enroll in the Plan before the next open enrollment unless I experience a change in family status during the plan year).

<u>SECTION III - YOUR APPROVAL FOR IRS CODE SECTION 125</u>

I hereby apply for coverage under the benefit plan as specified above. I authorize CLARK ATLANTA UNIVERSITY to reduce my compensation as may be necessary to provide the Medical/Drug/Dental/Vision coverage as elected on a pre-tax basis as permitted by IRS Code Section 125. I understand this agreement shall be effective for the plan year ending December 3I. This agreement may not amended as to the plan type and benefit elections during the plan year except as permitted by IRS Code Section 125 (addition or deletion to the family unit or a change in my spouse's job resulting in a change in our family's insurance coverage).

EMPLOYEE SIGNATURE: _____ **DATE:** _____

DEPENDENT INFORMATION

List all Dependent(s) you are enrolling in benefits and provide Social Security Number(s) below:

Note: The Social Security Number for all Dependents **must be provided** in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

Name: (Last) _______________ (First) ________________ (Maiden/Middle Name) ______________
Suffix: (Junior, Senior) ____________ Social Security Number: ____-____-_____Gender: ○Male ○Female
Date of Birth: (mm/dd/yyyy) __ /__ /____ Relationship: ○Spouse ○Other ______________________

Name: (Last) _______________ (First) ________________ (Maiden/Middle Name) ______________
Suffix: (Junior, Senior) ____________ Social Security Number: ____-____-_____Gender: ○Male ○Female
Date of Birth: (mm/dd/yyyy) __ /__ /____ Relationship: ○Child ○Other ______________________

Name: (Last) _______________ (First) ________________ (Maiden/Middle Name) ______________
Suffix: (Junior, Senior) ____________ Social Security Number: ____-____-_____Gender: ○Male ○Female
Date of Birth: (mm/dd/yyyy) __ /__ /____ Relationship: ○Child ○Other ______________________

Name: (Last) _______________ (First) ________________ (Maiden/Middle Name) ______________
Suffix: (Junior, Senior) ____________ Social Security Number: ____-____-_____Gender: ○Male ○Female
Date of Birth: (mm/dd/yyyy) __ /__ /____ Relationship: ○Child ○Other ______________________

Name: (Last) _______________ (First) ________________ (Maiden/Middle Name) ______________
Suffix: (Junior, Senior) ____________ Social Security Number: ____-____-_____Gender: ○Male ○Female
Date of Birth: (mm/dd/yyyy) __ /__ /____ Relationship: ○Child ○Other ______________________

EMPLOYEE SIGNATURE: ____ **DATE:** ____________________