1600 West Broadway Road, Suite 300
Tempe, Arizona 85282
Phone: (888) 811-8944
Fax: (866) 814-3854

Employee Enrollment Form

Please complete all sections to prevent any delay in enrollment.
For questions regarding this form, email
Enrollment@verdegard.com

SECTION A: QUALIFYING EVENT (Please Select One Option)

Employee

- ☐ **New Hire/Open Enrollment**
- ☐ **Termination:** (Date) ______/______/________
  Reason for Termination: ____________________
- ☐ **Transfer of Coverage:** From ____________________
- ☐ **Name Change:** From ____________________
- ☐ **Decline Coverage:** Reason ____________________
- ☐ **Dual Coverage** ☐ **Reinstatement**
- ☐ **New ID Card** ☐ **Salary Change**

Dependent

- ☐ **Add/Delete Dependents** (Must Complete Section C)
  Please Select Qualifying Event (Must Provide Documentation)
  ☐ **New Birth** ☐ **Divorce** ☐ **Adoption** ☐ **Marriage**
  ☐ **Other:** Please explain ____________________
  Date of Qualifying Event: ______/______/________
- ☐ **Termination** (Date) ______/______/________
  Reason for Termination: ____________________
- ☐ **Address Change**

SECTION B: EMPLOYEE INFORMATION

Employer Name ____________________ Position / Title ____________________ Employee Census Number ____________________

Social Security Number ______ - ______ - ______ Employee First Name ____________________ Employee Last Name ____________________

Employee ID Number ____________________ Date of Birth ______/______/________ Phone Number ____________________ Email Address ____________________

Home Address (Mailing) ____________________ City ____________________ State ______ Zip Code ______

Gender:
☐ Male
☐ Female

Marital Status:
☐ Single
☐ Married
☐ Common Law

Coverage Selected:
☐ Employee Only
☐ Employee & Spouse
☐ Employee & Family
☐ Employee & Child(ren)
☐ Dual Spouse

Coverage Desired:
Employee: ☐ Health ☐ Life ☐ Disability
Spouse: ☐ Health ☐ Life
Child(ren): ☐ Health ☐ Life

SECTION C: DEPENDENT INFORMATION (ALL INFORMATION IS MANDATORY) (“A” Add, “C” Change, “D” Delete)

“A”	“C”	“D”	First Name, Last Name, M.I.	Census #	Social Security Number	Date of Birth	Gender		Grand-Child	
☐	☐	☐	**Spouse:**				M	F	Y	N
☐	☐	☐	**Child:**				M	F	Y	N
☐	☐	☐	**Child:**				M	F	Y	N
☐	☐	☐	**Child:**				M	F	Y	N
☐	☐	☐	**Child:**				M	F	Y	N

If dependent coverage is elected, a photocopy of the Birth Certificate and Social Security card for each dependent must be submitted within 31 days from date of enrollment.

SECTION D: OTHER INSURANCE

Is there any other Group Insurance for you or your family members? ☐ **Yes** ☐ **No**
If yes, please list individuals covered and what type of coverage.

Employer Name: ____________________
Individuals Covered: ☐ Employee ☐ Spouse ☐ Child(ren)

Type of Coverage:
Employee: ☐ Medical ☐ Dental ☐ Vision
Spouse: ☐ Medical ☐ Dental ☐ Vision
Child(ren): ☐ Medical ☐ Dental ☐ Vision

Insurance/TPA Carrier: ____________________
Effective Date ______/______/________
Contract Holder Name: ____________________
Contract Holder Date of Birth: ______/______/________
Plan/Policy Number: ____________________

SECTION E: DISCLAIMER INFORMATION

I represent that all answers given are full, complete and true to the best of my knowledge, information and belief.
AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, reinsurer, or any other drug organization to give my employer or Verdegard Administrators, LLC. all information on my behalf including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be covered. I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original.
AUTHORIZATION FOR PAYROLL DEDUCTION: I hereby authorize my Employer to deduct any health, life and disability insurance premium from my paycheck.

Employee Signature: ______________________________ **Date:** ______/______/________

FOR HR USE ONLY – DO NOT WRITE BELOW THIS LINE

Annual Salary: | **Date of Hire:** __________ | **Effective Date:** **Health:** __________ **Life:** __________ **Disability:** __________

Employer/Administrator Signature: ______________________________ **Date:** ______/______/________