HealthSmart
SMARTER HEALTHCARE SOLUTIONS

Benefits Enrollment
Health – Dental - Vision

P.O. Box 42096 ▪ Oklahoma City, OK 73123-3005 ▪ 800.825.3540

Instructions
1. Please use ink. If you are using the three-part version of this form, please press firmly.
2. Submit completed form to your Human Resources Department.

☐ New Enrollment
☐ Re-Enrollment

EMPLOYEE INFORMATION

Employee Name (Last, First, Middle Initial)	☐ Male ☐ Female	Birthdate	Social Security No.
Home Address (Street, City, State, Zip)		Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Group Plan Number	Employer Name	Phone Work	Phone Home
Employer Address (your location)		Email Address	
Occupation	Earnings $ ☐ Hour ☐ Month ☐ Week ☐ Annual		Date of Full-Time Employment

Medical	Dental	Vision	Other
Effective Date MM DD YYYY	Effective Date MM DD YYYY	Effective Date MM DD YYYY	Effective Date MM DD YYYY
☐ Single (Employee only) ☐ Employee & Spouse only ☐ Employee & Dep. Children only ☐ Family (Employee & Dependents)	☐ Single (Employee only) ☐ Employee & Spouse only ☐ Employee & Dep. Children only ☐ Family (Employee & Dependents)	☐ Single (Employee only) ☐ Employee & Spouse only ☐ Employee & Dep. Children only ☐ Family (Employee & Dependents)	☐ Life – Amount: ☐ LTD: ☐ Dep Life: ☐ STD: ☐ Supp Life:

Spouse Name (Last, First, Middle Initial)	Date of Birth	Social Security No.	Gender	Resides with You Permanently?	Disabled	Has or is Eligible for Other Insurance Coverage:
1.			☐ Male ☐ Female	On a full-time basis? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Employer/Group ☐ Medicare ☐ Medicaid ☐ Other:

Is Spouse Employed? ☐ Yes ☐ No — If Yes, Provide Employer Name, Address, Phone

Dependent Name (Last, First, Middle Initial)	Date of Birth	Social Security No.	Gender	Relationship to You	Disabled	Has or is Eligible for Other Insurance Coverage:
2.			☐ Male ☐ Female		☐ Yes ☐ No	☐ Employer/Group ☐ Medicare ☐ Medicaid ☐ Other:
3.			☐ Male ☐ Female		☐ Yes ☐ No	☐ Employer/Group ☐ Medicare ☐ Medicaid ☐ Other:
4.			☐ Male ☐ Female		☐ Yes ☐ No	☐ Employer/Group ☐ Medicare ☐ Medicaid ☐ Other:
5.			☐ Male ☐ Female		☐ Yes ☐ No	☐ Employer/Group ☐ Medicare ☐ Medicaid ☐ Other:

Primary Beneficiary	Social Security No.	Relationship to you	Address (Street, City, State, Zip)

OTHER INSURANCE COVERAGE

When coverage becomes effective with HealthSmart if you or a family member listed above will continue to be enrolled in any other insurance plan, please complete information below.

Person(s) Insured	Type of Coverage	Insurance Company (Name, Address)	Plan/Group Number

ACCEPTANCE AND AUTHORIZATION

I hereby apply for benefits under the Group Benefit Plan(s) provided by the Company subject to all of its terms, conditions, and provisions. If a contribution toward the cost is required, I authorize the necessary deduction from my earnings.

Employee Signature For **AUTHORIZATION**	Date

REFUSAL OF ALL GROUP MEDICAL PLAN BENEFITS

This is to certify that I have been given the opportunity to examine the group benefits available to me and to apply through my employer; and I have decided NOT to apply for group benefits for: ☐ Myself ☐ My Dependents

I have other group insurance with:	Carrier/Administrator	Employer/Group

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Employee Signature for **REFUSAL**	Department/Division	Date