

US HEALTH AND LIFE INSURANCE COMPANY
C.O.P.S. HEALTH TRUST

_____ Medical
_____ Dental
_____ Vision

ENROLLMENT FORM

_____ NEW _____ Change/Add

LAST NAME | FIRST NAME | INITIAL

HOME ADDRESS | CITY | STATE | ZIP CODE

SOCIAL SECURITY NO. | DATE OF BIRTH | TELEPHONE NO. | SEX | MARITAL STATUS:

E-MAIL ADDRESS | MARRIED _____
SINGLE _____
DIVORCED _____
WIDOWED _____

ACTIVE _____ RETIRED _____ OTHER _____

NAME OF EMPLOYER | DATE EMPLOYED

NAME OF SPOUSE | SPOUSE SOCIAL SECURITY NO. | EMPLOYER | BIRTH DATE

DEPENDENT'S NAME | RELATIONSHIP | SOCIAL SECURITY # | BIRTH DATE

DEPENDENT'S NAME | RELATIONSHIP | SOCIAL SECURITY # | BIRTH DATE

USE OTHER SIDE FOR ADDITIONAL DEPENDENTS

IF THERE IS ANY OTHER HEALTH INSURANCE COVERAGE PLEASE COMPLETE THE FOLLOWING

Insurance Company: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number (____) _____ Policy Number: _____

CHECK IF ANY FAMILY MEMBER HAS MEDICARE: Yourself _____ Spouse _____ Dependent(s) _____

IF YES, PLEASE ATTACH COPY OF MEDICARE CARD.

Signature _____ Date Signed _____

FOR US HEALTH AND LIFE USE ONLY:

Effective Date: _____ Coverage: _____

Group No. _____ Class No. _____ PSC Group No. _____

Sent to: _____ ABS _____ PPOM _____ HAN

BY: _____