



**Employee Information**

LAST NAME	FIRST	INITIAL	EMPLOYEE ID NO.
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**Child Custody Information**

If you or your spouse are divorced or legally separated, please indicate who has custody of your child(ren).	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Has the parent without custody been mandated by court decree to provide coverage for the dependent child(ren)?	<input type="checkbox"/> Yes If yes, complete the "Family Members Covered Under Other Coverage" section below. <input type="checkbox"/> No

**Family Members Covered Under Other Coverage**

To be completed only if you, or a dependent you are enrolling through the Trust, has other insurance.

NAME OF FAMILY MEMBER WITH OTHER COVERAGE	DATE OF BIRTH	NAME OF OTHER INSURANCE PLAN
NAME OF EMPLOYEE	GROUP ID NUMBER	EFFECTIVE DATE OF COVERAGE
CLAIMS ADDRESS		

**Medicare Eligibility**

Completion of this information is required.

Name	Enrolled in Medicare? (If Yes, you must send copy of Medicare Card)		Check Box if Applicable	Date Dialysis Began or Date of Transplant (MM/DD/YY)
	Part A	Part B		
SELF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
SPOUSE/DOMESTIC PARTNER	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
DEPENDENT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
DEPENDENT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	
DEPENDENT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Transplant	

**Signature**

My signature below indicates that I have read and understand this enrollment form and descriptive materials provided. This enrollment form is binding on me and cannot be revoked or modified except as explained in the descriptive materials provided. I authorize my insurance carriers to obtain, examine, or release any medical or dental records or other information needed to coordinate benefits or process claims for me and my family members. I also authorize any provider having knowledge of my medical history or my dependents to release to my insurance carriers any medical information it requests. I authorize my insurance carriers to share such medical information with me or my dependents' health care providers. I declare that the dependents listed on this form are my eligible dependents. I also declare that the information furnished on this form is correct and complete to the best of my knowledge.

SIGNATURE VERIFYING I'VE READ AND UNDERSTAND MATERIAL	DATE
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