



Eligibility Enrollment/Update

Vision

Group/Subgroup# _____

Group Name Superior Coal Services

Plan Enrollment/Update Information (please indicate type of update and fill in appropriate information)

Type of Update: New Enrollment Reinstatement Change/Correction to Information Termination of Benefits

Group Transfer From: Group/Subgroup# _____ To: Group/Subgroup# _____ Rate Code Change From: _____ To: _____ Effective Date of Change _____ Change is for:
 Certificate Holder
 Dependent

Certificate Holder Information (please complete for all enrollments/updates) Social Security # _____

First Name _____ MI _____ Last Name _____

Street Address _____ Check if New Address

City _____ State _____ ZIP Code _____ E-mail address _____

Status: Active COBRA Retiree Surviving Job Title _____

Birth Date _____ Date of Hire _____ Coverage Effective Date _____
MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY

Enrollment/Corrections to Information (please fill in for spouse/dependents for first-time enrollment or corrections)

SPOUSE

First Name _____ MI _____ Last Name, if different _____

Birth Date _____ SSN _____ Status: Legal Surviving Dental Vision
MM/DD/YYYY

DEPENDENT #1

First Name _____ MI _____ Last Name, if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Dental Vision
MM/DD/YYYY

DEPENDENT #2

First Name _____ MI _____ Last Name, if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Dental Vision
MM/DD/YYYY

DEPENDENT #3

First Name _____ MI _____ Last Name, if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Dental Vision
MM/DD/YYYY

DEPENDENT #3

First Name _____ MI _____ Last Name, if different _____

Birth Date _____ SSN _____ Status: IRS Surviving Dental Vision
MM/DD/YYYY

Employee Name _____ Employee ID _____

I request coverage under my employer's group insurance plan and authorize my employer to make deductions from my earnings of the required contributions, if any, toward the cost of the coverage. I will be provided a certificate of coverage in either electronic or paper form. The electronic delivery of my certificate of coverage must be pursuant to the Terms for Paperless Delivery (attached to this form). Such terms provide the manner in which I can request a paper copy at any time.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature _____ Date _____