

SELECT BENEFIT ADMINISTRATORS ENROLLMENT / UPDATE FORM

Company: _____ Group No: _____ Loc/Dept: _____ Month/Year: _____

Submitted By: _____ Phone #: _____

NEW EMPLOYEES

Please list each new plan participant. **AN ENROLLMENT FORM MUST BE ATTACHED FOR EACH NEW PARTICIPANT.**

Coverage Effective Date	Last Name	First Name	MI	Social Security Number	Dept / Location	HIPAA Cert (Y / N)

CHANGE IN COVERAGE / ENROLLMENT INFORMATION ⁽²⁾

Please list each employee who is changing any piece of enrollment information (location change, marriage, divorce, new dependent, life volume change, new name, address, etc.) **PLEASE ATTACH AN ENROLLMENT FORM NOTING THE CHANGED INFORMATION.**

Change Effective Date	Last Name	First Name	Social Security Number	Reason for Change ⁽¹⁾ (Required)	Enrollment Enclosed (Y / N)

TERMINATIONS ⁽²⁾

Please report terminations regularly to avoid payment of ineligible claims. Insurance carriers and SBA allow up to three months credit for retroactive terminations.

Coverage Term Date	Last Flex Contribution Date	Last Name	First Name	Social Security Number	Reason for Change ⁽¹⁾ (Required)

⁽¹⁾ Divorce, Death, Loss of Dependent Status, Termination of Employment, COBRA, Voluntary Coverage Termination, etc.
⁽²⁾ Please be advised that if employee premiums are paid pre-tax, the Pre-Tax / Flexible Benefit Plan Document should be consulted for compliance with Federal Section 125 regulations, (e.g. when a person can discontinue enrollment in a plan).