

ADMINISTERED BY:

C. L. Frates and Company – Health Services
 5005 N. Lincoln Blvd., PO Box 269001
 Oklahoma City, Oklahoma 73126-9001
 Ph: (800) 850-7166 Fax: (405) 290-5717



Enrollment Form

OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	EFFECTIVE DATE		
EMPLOYER USE ONLY	EMPLOYER COMPANY	DIVISION	EMPLOYEE JOB TITLE	DATE OF HIRE

APPLICANT INFORMATION

MEDICAL COVERAGE TYPE

Single Only
 Single + Child / Children
 Single + Spouse
 Family

DENTAL COVERAGE TYPE

Single Only
 Single + Child / Children
 Single + Spouse
 Family

LIFE COVERAGE TYPE

Single Only Dependent

EMPLOYEE CLASS

Owner Management Other

Last Name	First	MI	Date of Birth	Gender	Height	Weight	Social Security Number
Address (Mailing)		Apt No.	City	State		Zip Code	
Home Telephone	Work Telephone	E-mail Address		<input type="checkbox"/> YES <input type="checkbox"/> NO Currently work 30 hours per week?			
* Covered by other Insurance, Medicare or COBRA? * <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, Name of Health Plan			

BENEFICIARY INFORMATION

(Complete only if you intend to elect Life Coverage.)

Beneficiary	Relation				
Address	Apt No.	City	State	Zip Code	Phone Number

DEPENDENT INFORMATION

(Complete only if you intend to cover your family members.)

SPOUSE						
Spouse's Full Name	Date of Marriage	Date of Birth	Height	Weight	Social Security Number	
Employed By	Covered by other Insurance, Medicare or COBRA? * <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Plan			
DEPENDENTS						
Dependent's Full Name	Relation	Sex	Date of Birth	Height	Weight	Social Security Number
Is dependent unmarried and living with you in a parent child relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is Dependent a Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No, is it stated in a court decree that you are to provide health coverage for them? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, provide name of institution:			
If Yes, provide a copy of the decree.						
Covered by other Insurance, Medicare or COBRA? * <input type="checkbox"/> Yes <input type="checkbox"/> No			Employed By			
If Yes, provide name of plan						
Dependent's Full Name	Relation	Sex	Date of Birth	Height	Weight	Social Security Number
Is dependent unmarried and living with you in a parent child relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is Dependent a Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No, is it stated in a court decree that you are to provide health coverage for them? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, provide name of institution:			
If Yes, provide a copy of the decree.						
Covered by other Insurance, Medicare or COBRA? * <input type="checkbox"/> Yes <input type="checkbox"/> No			Employed By			
If Yes, provide name of plan						

* If you have indicated you or your dependent(s) are covered under another plan, please provide a Certificate of Creditable Coverage from the prior carrier. If you have any questions regarding this information, please contact our office.

IMPORTANT: THE REVERSE SIDE MUST BE SIGNED AND DATED.

