

ENROLLMENT/CHANGE FORM

These forms must be received at HealthSmart before the 15th of the month prior to requested effective date. Future new hire and qualifying event forms should be sent to: HealthSmart Benefit Solutions, Inc. Phone: (800) 786-6525

> FAX: (303) 804-9490 Email: PBDenver@healthsmart.com

FOR EMPLOYER USE ONLY
Group No
Contract Type
Effective Date

☐ New Enrollment ☐ New Social Security		Email: PBDenver@healthsmar	rt.com	
Name Change Number / Employee ID	Primary Enrollee Inform	nation VERYIMPORTANT - I	PLEASE PRINT LEGIBLY (Please leave	e one blank box between each word)
☐ Facility Change* ☐ Address Change ☐ Add Dependent ☐ Remove Dependent	Name:		(First)	(M.L.)
Indicate effective date of change: *(Does not pertain to facility change)	Mailing Address: (Street Address)			
(Month) (Day) (Year)	(City)	Male F	Home	
CORPA Envallment Only	Date of Birth I I (Day)	(Year) Female F	Phone #: LLLL) L	
COBRA Enrollment Only	Name of Employer/Group:			
Please indicate qualifying event: ☐ Termination ☐ ☐ Surviving	Location:			
☐ Divorce Widowed Dependent ☐ Overage Dependent	Soc. Security #:	En	mployee Identification #:	
Indicate qualifying date: L L L L L (Month) (Day) (Year)	Contract Facility Name:		Contr. 1 1 1 1 Facilit	1
Dependent Information VERYIMPORTANT BLEACE	DDINT I FOIDLY (To add additional dependen	eta mianan ettanlan annovata alanat \ Nictor Volum	any ahanan um ta thuan annavata affinan f	

DEPENDENT INTO MATERIAN VERY IMPORTANT - PLEASE PRINT LEGIRLY. (To add additional dependents, please attach a separate sheet.). Note: You may choose up to three separate offices for yourself and all dependent enrollees

PLEASE LIST FLIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELE

Relationshi	p Dependent Name									Gender	Date of Birth									Contract Facility Name												Contract Facility #:													
Code*									(CheckOne) M F	(Month)	(Day)	1	(Yea	ar)																														
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*Relationship Codes: Place the following two character code in the first column to designate each dependent as follows: Spouse - SP Domestic Partner - DP Child - CH Child of DP - CD Other Adult - OA Other Child - OC

NOTE: If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event.

Signature of Primary Enrollee Date:

NRBT-DeltaCare-HBS Rev. 080114