US HEALTH AND LIFE INSURANCE COMPANY

Employee Enrollment Form

Coalition Of Public Safety Employees Health Trust

A. Basic Information

☐ New ☐ Change/Add ☐ Waiver Effective Date_____ Start Date_____

Employer Name_____ I elect to enroll for: ☐ Check #: ☐ Vision

B. Employee Information This section must be completed

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name _____ MI_____ Last _____

Address_____

City_____ State_____ Zip_____

Date of Birth _____ Social Security Number _____

Daytime Phone Number_____ Email Address_____

☐ Active ☐ Retired ☐ Other Union Affiliation: _____

C. Dependent Information This section must be completed when enrolling your dependents (use additional paper if necessary)

Please complete the following for each affected individual.

First Name	MI	Last Name	Relationship	Date of Birth	Sex	Social Security No.**

D. Waiver This section must be completed if declining to enroll

I decline to enroll for ☐ Medical coverage and/or ☐ Prescription Drug coverage and/or ☐ Vision Coverage

☐ Myself ☐ My spouse and/or ☐ My children due to:

☐ Spousal coverage ☐ Existence of other health/vision coverage ☐ Other reason (explain)_____

Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption. I have read and understand the "Important Information" located on the last page of this form.

Sign below if declining coverage

Employee Signature_____ Date_____

E. Other Insurance Information If there is any other health insurance coverage please complete the following

Insurance Company_____ Address_____

City_____ State_____ Zip_____

Phone Number_____ Policy Number_____

Who is covered ☐ You ☐ Spouse ☐ Dependent

If any family member has Medicare, please check below and attach a copy of Medicare card

☐ You ☐ Spouse ☐ Dependent

Employee Signature_____ Date_____