



CLEMENTS INTERNATIONAL
 ONE THOMAS CIRCLE NW, 8TH FLOOR, WASHINGTON DC 20005
 1.800.872.0067 or 1.202.872.0060 FAX 1.202.466.9064

ENROLLMENT / CHANGE FORM

Instructions: Please make sure all questions are completed accurately. Late enrollees or groups with less than 10 covered employees must also complete an evidence of insurability form for each person.

<input type="checkbox"/> International Plan <input type="checkbox"/> Custom Plan		School Name:	
I would like to enroll in the following coverage: <input type="checkbox"/> Employee coverage only <input type="checkbox"/> Employee and eligible dependents			
This application is for:			
<input type="checkbox"/> New employee		<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Addition of dependent (s)
<input type="checkbox"/> Change of Status		<input type="checkbox"/> Removal of dependents (s)	
<input type="checkbox"/> Address change		<input type="checkbox"/> Name change	<input type="checkbox"/> Termination notice
Employee Name: (Last)		(First)	(Middle)
Requested Effective Date:		Occupation:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:			City:
State, Zip		Country, Telephone:	E-mail:
Identification Number:		Date of Birth:	Social Security Number/Passport Number:
Date of employed fulltime:	Annual Salary:	Hours worked per week:	Citizenship:

Dependents (Use "Comments & Explanations" Section if needed)

Name (Last, First, Middle)	Date of Birth & Date of Marriage to Spouse	Identification Number
Spouse		SS# PP#
Dependent Child #1 Sex: <input type="checkbox"/> M <input type="checkbox"/> F		SS# PP#
Dependent Child #2 Sex: <input type="checkbox"/> M <input type="checkbox"/> F		SS# PP#
Dependent Child #3 Sex: <input type="checkbox"/> M <input type="checkbox"/> F		SS# PP#
For dependent children age 19-23, please indicate name and address of college or university and the number of credit hours:		



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Has any person listed on the prior page, including dependents, been insured for medical expenses under any policy or plan during the last 12 months, whether individual or group? [] Yes [] No

If your response to the above question was "yes", the following is required:

- 1. Name of person (s)
2. A copy of all Certificates of Creditable Coverage

Note: Certificates of Creditable Coverage can be obtained from your prior insurer or employer. Failure to submit Certificates of Creditable Coverage may delay your effective date. Any claims submitted without Certificates of Creditable Coverage will be processed with any pre-existing condition exclusion as defined in the master group policy. Only the insured individual can obtain the Certificate of Credibility form an insurer.

Comments or explanations

Multiple horizontal lines for writing comments or explanations.

Signature and Verification

I hereby certify that I have read the above statements and all attachments or they have been read to me and the statements are true and complete to the best of my knowledge and belief. I understand that any representation contained herein will void the insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by the Company, and the Company has the right to refuse to grant coverage.

Employee's signature _____ Date _____

Important Note: Remember late enrollees or groups with less than 10 covered employees must also complete an evidence of insurability form for each person.

Waiver of Insurance

I refuse coverage for: [] Myself [] My Spouse [] My children
Reason: _____

I have been given the opportunity to participate in the insurance plan offered through my employer and I have refused to participate in the coverage as indicated above. I understand that if coverage is desired at a later date, I may be required to furnish, at my own expense, satisfactory evidence of insurability before coverage becomes effective. (SIGN HERE IF REFUSING COVERAGE)

Signature: _____ Date: _____