Office 229-225-9943
Fax 229-225-9945
Toll Free 888-35-CLAIM

TBR
Taylor Benefit Resource

164 Commercial Drive.
P. O. Box 6580
Thomasville, GA 31758

Enrollment Form

Employee Name		Social Security No.	
Address		Date of Birth	
City		State	ZIP
Life Amt & AD&D	Depend Life ☐ Yes ☐ No	Divison/Department/Location	Marital Status
		Hire Date	Effective Date

Type of Coverage Desired: (check one) List Dependents Below if covered

MEDICAL Participant ☐ Part/Child ☐ Part/Spouse ☐ Full Family ☐

List all other dependents below. Any dependents not on this form will not be covered by the plan without special medical approval. You must notify your Personnel Department with 31 days of any new dependents.

		RELATION	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
Spouse					
Child					

* SPECIAL NOTE FOR FOSTER OR STEP-CHILDREN: On the reverse side of this form you must list the name, address, employer, and any other insurance information for the natural parent(s)

OTHER COVERAGE

Spouse's Employer	Address	Phone No.
Spouse's Group Insurance Company	**Policy No.**	**Type of Coverage: Single ☐ Family ☐**

BENEFICIARY

Primary Beneficiary Name		Relationship
Street	**City**	**State & Zip**

The Beneficiary designation is applicable under any benefit plan or life coverage offered by the employer.

I request coverage under my Employer's Employee Benefit Plan and authorize the deduction of my share of the cost from my wages if applicable. I authorize any medical provider or hospital to furnish the Plan's Benefit Services Manager any records pertaining to the issue of all coverages indicated on this form. The statements above are true and correct to the best of my knowledge.

Employee's Signature_____ **Date**_____

☐ I do not wish to enroll in my Employer's Health plan at this time. I understand that I may not be able to enroll again.
☐ I am waiving Medical Coverage because I am covered through another Medical Plan.
☐ I am waiving my spouse's Medical coverage because he/she is covered by another Medical Plan
☐ I am waiving dependent Medical coverage because my dependents is/are covered by another Medical Plan

IMPORTANT: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of the legal papers.

If you are enrolling for the first time or adding Medical coverage for you or a spouse or dependent, you must provide a CERTIFICATE OF PRIOR CREDITABLE COVERAGE from the previous insurance provider in order to avoid delays in the payment of your claims.