The Difference Card

EB EMPLOYEE SOLUTIONS, LLC.

ENROLLMENT/CHANGE FORM

EMPLOYER NAME:

ELIGIBILITY REQUEST (PLEASE CHECK ONE)
☐ New Enrollment ☐ New Dependent ☐ Plan Change ☐ Termination

EMPLOYEE INFORMATION

EMPLOYEE NAME (First, Middle, Last):		
EMPLOYEE ADDRESS (Line 1):		
EMPLOYEE ADDRESS (Line 2):		DIVISION (IF APPLICABLE):
CITY, STATE, ZIP CODE:		SOCIAL SECURITY NUMBER:*
GENDER:	DATE OF BIRTH (MM/DD/YYYY):	E-MAIL ADDRESS:

DEPENDENT INFORMATION

SPOUSE	FIRST NAME	MIDDLE INITIAL	LAST NAME	
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME	
YES ☐ NO ☐	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME	
YES ☐ NO ☐	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME	
YES ☐ NO ☐	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT?	FIRST NAME	MIDDLE INITIAL	LAST NAME	
YES ☐ NO ☐	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:

I hereby attest to agree to all the terms and conditions in association with the Difference Card. I understand that upon the Difference Card being lost or stolen, I will notify my Human Resource department within 24 hours. Upon termination, I agree to return the difference card within one (1) business day.

EMPLOYEE SIGNATURE

DATE (MM/DD/YYYY):

Due to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), social security numbers must be included or **the form will be returned.*

EFFECTIVE DATE (MM/DD/YYYY):	ACTIVE ☐ COBRA ☐ (please check one)		
PLAN(S) ELECTED (Please enter Plan name as shown on your Difference Card Summary of Benefits)	**PLAN START DATE**	**PLAN END DATE**	**COVERAGE TIER**

APPROVED BY

DATE (MM/DD/YYYY):