

INFORMATION SHEET KBA re-enroll _____ PRODUCER: _____

COMPANY: _____
 CALL BACK NUMBER: _____ E mail _____
 DATE: _____ EFFECTIVE DATE: _____ ENROLLER: _____

EMPLOYEE NAME	
SS #	
GENDER	
DATE OF BIRTH	
ADDRESS	
CITY, STATE ZIP	
SINGLE / MARRIED	
DATE OF MARRIAGE	
SMOKER/NON SMOKER	
DATE enrolled in FHA	
OCCUPATION	
HEIGHT	
WEIGHT	
GROSS ANNUAL SALARY	

**DEPENDENT INFORMATION
SPOUSE**

NAME	
SS #	
GENDER	
DATE OF BIRTH	
SMOKER/NON SMOKER	
HEIGHT	
WEIGHT	

CHILDREN

FIRST NAME	LAST NAME	GENDER	DOB	SS #	FULL TIME STUDENT

COVERAGE ELECTIONS

	MED	RX ONLY	DN	VS	STD	LTD	CI w/TL	ADD	TL	Legal	ACC	AF
EE												
EE+SP												
EE+1CH												
EE+CH'S												
FAM												

BENEFICIARY: _____

CONTINGENT: _____