

- New Enrollee
- Change of Enrollment

CEBT Enrollment / Change Card

Please type or print in ink. Press firmly.

Employer - Complete all shaded areas at the top of the card.

Employee - Complete all unshaded areas.

Name of employer	Date of Full Time Eligibility	Salary	Effective Date (Required)	Branch #
1. Employee's Name (last, first, middle initial)		2. Social Security #		3. Date of Birth
4. Employee's mailing address Street City State Zip				5. Male <input type="checkbox"/> Female <input type="checkbox"/>
6. Beneficiary's name		7. Relationship to you		

8.	PPO I	PPO II	PPO III	PPO IV	PPO V	PPO VI	HD15	HD25	EPO II	EPO III	EPO IV	HRP	Dental	Vision	Life
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee & Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee & Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee & Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(MPA Only)	PA	PB	PC	PD	PE	PF	HA	HB	EB	EC	ED	RA	D/B/N	V/W	

9. Do you want dependent coverage? yes no If yes, complete below:

Last, First	Social Security Number (Required)	Date of Birth	Gender	Enrolled in Medicare?
1. Spouse				Y / N
2. Dependent Child				Y / N
3. Dependent Child				Y / N
4. Dependent Child				Y / N
5. Dependent Child				Y / N
6. Dependent Child				Y / N

10. PLEASE CHECK ONE:

Add Spouse Effective Date _____ Marriage Drop Spouse Effective Date _____ Divorce

Add Dependent(s) Drop Dependent(s) Beneficiary Change Name Change Address Change

Unless otherwise provided herein, If two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries if surviving the insured, or the survivor of survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

11. Employee's signature _____ Home Phone # _____ 12. Date signed _____

FOR MPA USE ONLY				COV. TYPE (20) e s c f					
BENEFIT CLASSES (four digits)				VOLUMES *(if applicable, enter 1000 for DEP and/or DEP VLIF)					
EFFECTIVE DATE	EE (23 EE)	SP (23 SP)	CH (23 CH)	Enrollee (01)	*DEP (Member 03)	Supplemental (04)	Short Term (06)	Long Term (07)	*DEP VLIF (09)

Return original to Willis of Colorado, and retain a copy for your records.