☐ New Enrollee
☐ Change of Enrollment

CEBT Enrollment / Change Card

Please type or print in ink. ***Employer – Complete shaded area at the top of the card.*** ***Employee – Complete non-shaded areas.***

Name or 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 ☐ Female ☐

6. Beneficiary's name	7. Relationship to you

8.	PPO						HDHP		EPO			HRP	DENTAL	VISION	LIFE	DEP LIFE
	2	3	4	5	6	7	HD2600	HD5000	3	4	5					
Employee Only	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
Employee & Spouse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐
Employee & Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐
Employee & Children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐
Family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐

If you are enrolling in Kaiser you will also need to complete the Kaiser enrollment application.
☐ Check here to indicate Kaiser election form is attached

Please access a copy of the new Summary of Benefits and Coverage (SBC) at www.cebt.org.

9. Do you want dependent coverage? yes ☐ no ☐ If yes, complete below and provide proof of legal dependency such as Certificates of birth, marriage, common law, civil union and adoption.

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

***CEBT Hospital Reimbursement Plan (HRP) Acknowledgement**
I have read, understand and agree that by enrolling in the CEBT Hospital Reimbursement Plan (HRP) that this coverage will be secondary. The HRP will only pay benefits for unreimbursed eligible hospital expenses after my primary plan has processed the charges. The benefits under the HRP will be up to a $1,000 per day and up to $30,000 calendar year maximum.

I have read and understand the benefits information provided and I am aware that changes may only be made during the annual open enrollment period of if I have a HIPAA qualifying event.

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)	**SP** (23)	**CH** (23)	**Enrollee** (01)	***DEP (**Member 03)	**Supplemental** (04)	**Short Term**	**Long Term**	***DEP VLIF**

Return original to Willis of Colorado, yellow copy to be retained by the employee/employer.