

Please either mail this form to SIHO, 417 Washington Street, Columbus, IN 47201
attn: Membership, fax it to 812-373-8717 or email to membership@siho.org.

For these sections, please also complete reverse side

Employer _____ Group No. _____
 Employee _____ ID # _____ Phone (____) _____

Add Spouse

Name _____ Hgt/Wgt _____ Date of Birth _____
 Reason to add _____ Spouse employed: Yes No Spouse's S.S. # _____
 What is the Qualifying Event: _____ Date of Qualifying Event _____
 If enrollment is due to a qualifying event, proof of qualifying event (marriage license, Cert. of Creditable Coverage, etc.) **must** accompany this form.
 Employer Name/Address _____
 Spouse insured elsewhere? Yes No If yes, Insured by _____ Policy #: _____

Add Children

Full Name	Sex M / F	Birthday M/D/Y	S.S. Number	Full Time Student (Y/N)	Reason to Add	Date of Qualifying Event

Children insured elsewhere? Yes No If yes, Insurance Co.: _____ Policy #: _____
 Are any of the other Dependents listed above in the legal custody of another person? Yes No If yes:

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

Termination And Changes

Employee Termination, indicate last day of work _____ Voluntary Involuntary

Employee Request for Termination of Benefits:
 Delete employee coverage, effective date _____ Reason: _____
 Please check which coverage(s) to delete: Medical Dental Vision

Delete spouse's coverage, effective date _____ Reason: _____
 Please check which coverage(s) to delete: Medical Dental Vision

Delete children's coverage, effective date _____ Reason: _____
 Please check which coverage(s) to delete: Medical Dental Vision

Change marital status
From: Single Divorced Separated **To:** Married Divorced
 Married Widowed Separated Widowed

Change Name: Employee Name Dependent's Name _____
 Reason: Marriage Divorce Other, describe _____
 Change Name to _____

Change address New Address _____

Change Life Insurance Beneficiary
 Full Name _____ Relationship _____

I authorized SIHO to make the above changes to my current benefits.
Note: No employee signature is necessary if employment is terminated. All other changes must be authorized by the employee.

Employee signature: _____ Date: _____ Employer signature: _____

WARNING: any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

Medical Conditions (please check Yes or No)

1. Has any person listed above been advised that **hospitalization or surgery** is needed or anticipated? **Yes** **No**
2. Has any person listed above in the **past five (5) years** been diagnosed, received treatment, or had medication prescribed for, but not limited to, the following conditions: Cancer; Stroke; Diabetes; Heart or Vascular Disease; Mental or Emotional Disorder; Muscular or Systemic Disease (Arthritis / Lupus); Alcohol / Drug Abuse; Liver; Kidney; Lung or Intestinal Disorder; AIDS / HIV? **Yes** **No**

Please provide details to your answers in the space provided below:

Question #	Covered Person	Height/ Weight	Illness/ Condition	Date of Diagnosis/ Treatment	Physician or Hospital

To the best of my knowledge, all of the above information is believed by me to be true.

Signature of Employee

Date