BAI NEW ENROLLMENT FORM

☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **STD**

Employee: Last Name	First Name	Middle Initial	
Social Security #	Date Of Birth	Male	Female
Address	City	State	Zip

COVERAGE FOR:

☐ SINGLE ☐ WIDOW ☐ EMPLOYEE ONLY
☐ MARRIED ☐ DIVORCED OR SEPARATED ☐ EMPLOYEE AND DEPENDENTS

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU ARE COVERING YOUR DEPENDENTS

Name	Soc. Sec . #	Relationship	Date of Birth	Sex	Primary Care Physician	PCP #	Established patient
1.		Self					
2.		Spouse					
3.							
4.							
5.							
6.							

Is your spouse employed? ☐ **YES** ☐ **NO**

If so, name and address of employer and name and address of carrier / TPA providing medical/ dental coverage:

☐ **If the plan provides that any contributions be made by me. I authorize my Employer to deduct them from my pay.**

☐ **I elect not to participate in the Dental Assistance Plan.**

☐ **I elect not to cover my dependents under the Dental Assistance Plan.**

☐ **I elect not to participate in the Medical Plan.**

☐ **I elect not to cover my dependents under the Medical Plan.**

I certify that I am an active full time employee for the employer named below:

Mo. Day Year **Signature Of Employee**

EMPLOYER'S STATEMENT

Effective Date Mo. Day Year / **Hire Date** Mo. Day Year	**Occupation:**
Name of Employer:	**Co I.D. No.**

Employer-Authorized Signature and Title

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