

Open Enrollment Event

- About You
- Your Doctor
- Enrollment Summary

- 1 Select Benefits 2 **Sign Up** 3 Confirm Enrollment

Exit Event

Here's where you provide us with information about yourself and any eligible dependents, and add or remove coverage for the available benefits indicated below. Please enter all information accurately.

Add More Dependents

Primary Member Information

* denotes a required field

* First Name: MI:

* Last Name: Suffix:

* Date of Birth: / / (mm/dd/yyyy)

* Gender: male female

* Address line 1:

Address line 2:

* City:

* State / Province: * Zip: + 4

* Country:

* Primary Phone #:

* Is this a US/Canadian phone number? Yes No

Medical Benefit
01/01/2007-12/31/2007

Dental Benefit
01/01/2007-12/31/2007

FSA Benefit
01/01/2007-12/31/2007

Disability Benefit
01/01/2007-12/31/2007

Life Insurance Benefit
01/01/2007-12/31/2007

[How Do I...](#)

Dependent Information

* First Name: MI:

* Last Name: Suffix:

* Date of Birth: / / (mm/dd/yyyy)

* Gender: male female

* Relationship:

* Is this person over the dependent cutoff age and a full-time student? yes no

* Is this person over the dependent cutoff age and disabled? yes no

Check The Box(es) Below to [Add Coverage For This Dependent](#)

Medical Benefit
 01/01/2007-12/31/2007

Dental Benefit
 01/01/2007-12/31/2007

[How Do I...](#)

Delete Dependent

Dependent Information

* First Name: MI:

* Last Name: Suffix:

* Date of Birth: / / (mm/dd/yyyy)

* Gender: male female

* Relationship:

* Is this person over the dependent cutoff age and a full-time student? yes no

* Is this person over the dependent cutoff age and disabled? yes no

Check The Box(es) Below to [Add Coverage For This Dependent](#)

Medical Benefit
 01/01/2007-12/31/2007

Dental Benefit
 01/01/2007-12/31/2007

[How Do I...](#)

Delete Dependent

Other Coverage Information

* Are you or any dependents covered by another health plan? yes no

If you answered yes, please provide the following:

Name of the other health plan:

* Are you or any dependents covered by another dental plan? yes no

If you answered yes, please provide the following:

Name of the other dental plan: