State Health Plan

Information Only

EMPLOYEE INFORMATION (To be completed by employee)

Social Security # _____ Date of Birth _____

First Name _____ MI ___ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Job Title _____

TYPES OF COVERAGE (To be completed by employee)

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Employee + Family
- ☐ Decline Coverage

PLAN SELECTION

- ☐ 80/20 PLAN
- ☐ 70/30 PLAN

DEPENDENT INFORMATION (To be completed by employee)

First Name	MI	Last Name	Sex	Date of Birth	Relationship	SS #

I understand that this form is for information only. It is my responsibility to enroll in or decline coverage under the State Health Plan by calling or visiting the SHPNC website. I acknowledge that I was provided with the contact information and the necessary information to make my Major Medical Plan selection.

_____ _____

Signature Date

EMPLOYER INFORMATION (For Employer use only)

Hire Date _____ Plan Selected _____

Enrollment Date _____ Date Entered into LINQ _____

Effective Date _____ Entered By _____