Information Only

	EMPLOYEE INFORMATION (To be completed by employee)							
	Social Security #			1	Date of Birt			
	First Name			`MI	Last Name	e		
	Street Address							
	City Star				e			
	Phone #		***************************************	-	Job Title			
	TYPES OF COVERAGE (To be completed by				oloyee)	PLAN SELECTION		
	Employee Only	byee Only						
	Employee + Child(ren)			contractive devices and the second of the se		80/20 PLAN		
	Employee + Spouse				Millionius vierne veg Millionius veg Millioni			
	Employee + Family				70/30 PLAN		PLAN	
	Decline Coverage			Antings have been				
DEPENDENT INFORMATION (To be completed by employee)							1.47499411111111111111111111111111111111	
	First Name	MI	Last Name	Sex	Date of Birth	Relationship	SS#	
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							1100 2007-1100 1007	
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.								
		Sig	Signature			Date		
	· · · · · · · · · · · · · · · · · · ·							
	EMPLOYER INFORMATION (For Employer use only)							
	Hire Date	lire Date				Plan Selected		
	Enrollment Date	ent Date				Date Entered into LINQ		
	Effective Date	tive Date				Entered By		