Group Health Insurance Reinstatement Application

Group/Employer Information

Group/Employer Name

Group Number

Employer Contact Name

Employer Email

Employer Phone

Employee/Member Information

Employee Name

Member ID

Date of Birth

Email

Phone

Coverage Details

Requested Effective Date of Reinstatement

Coverage Type

Reason for Reinstatement

Declaration and Authorization

By signing below, I certify that the information provided is true and complete to the best of my knowledge.

Employee Signature

Date

Employer Signature

Date