Small Business Health Benefits Enrollment Form

First Name

Last Name

Date of Birth

SSN (Last 4 Digits)

Home Address

City

State

ZIP Code

Phone Number

Email Address

Coverage Type

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Plan Selection

Select Plan

Dependent Information (if applicable)

Dependent 1 Name

Date of Birth

Relationship

Dependent 2 Name

Date of Birth

Relationship

Additional Notes