



Enrollment & Change Form

JAD Solutions, LLC
 P O Box 5068
 Bend, OR 97708
 541-318-5968 Phone
 866-318-5968 Toll Free
 541-318-5978 Fax

- New Employee
 Change Name / Address
 Add Dependent
 Termination
 Decline Coverage
 COBRA Enrollment
 Delete Dependent
 Open Enrollment

Employee Information

Last Name	First Name	Middle Name
Mailing Address	City, State	Zip
Home Phone	Social Security #	Birth Date
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced	

Dependent Information

1) Spouse full name	Social Security #	Birth date	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
1) Dependent full name	Social Security #	Birth date	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
2) Dependent full name	Social Security #	Birth date	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
3) Dependent full name	Social Security #	Birth date	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
4) Dependent full name	Social Security #	Birth date	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
5) Dependent full name	Social Security #	Birth date	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

Coverage Category

Coverage Type	Employee	Spouse	Child / Children
Medical / RX / Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Coverage Changes (all changes require supporting documentation)

Date of Event	Qualified status change event			Description of event (required)			
Current Coverage	Employee	Spouse	Child/Children	Requested Coverage	Employee	Spouse	Child/Children
Medical / RX / Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical / RX / Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	List Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Termination Only				Date Coverage Ends (MM/DD/YY)			
Date of event (MM/DD/YY)							

Signature

I, the undersigned, give JAD Solutions, LLC (and its agents) authorization to access my medical records or those of my covered dependents in order to facilitate the processing of claims or to determine eligibility.

Employee Signature (required)	Date (required)
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<input type="checkbox"/>	ECI
<input type="checkbox"/>	PBM
<input type="checkbox"/>	ID Card
<i>Office use Only</i>	