F	Pace Univers	sity Med	lical Pla	n En	rollment	t/NY Y	oung A	dult Op	tion	
Check all that ap	ply: New Enrollmer		Qualifying Event	□ Te	rmination					
Primary Insured		Lingsbland				L First Nissa	- 0. M* dalla La	201-1		
Social Security N	l0.	Last Name			First Name & M			iddle initial		
Full time Date of Hire*	Home Address			С	ty		State	Zip C	Code	
Work Phone #*	Home Phone #	! Bir	rthdate	□Fem	Gender ale □Male	□Single □ Regis	Marital St □Married stered Domes	□ Divorced	Employment Status Active Retiree LTD	
*Only Complete i	f currently employed a	t Pace Univers	sity							
Health Care Enro	ollment									
I am choosing me	edical coverage for:									
□ Individual	-	☐ I am Termir	nating Young A	Adult Op	tion Medical Co	overage				
Medical Coverage	ge*: Please note for t	he Young Adı	ult Option, the	plan se	lection must l	be the same	as the cov	ered parent.		
☐ High Deducti	ble Health Plan (HDH	IP)	□ Ne	twork C	ore Plan					
□ Choice Plan										
	ge under the Young								participants, who are er COBRA.	
I am also electir	ng to continue vision	coverage for	my dependen	ıt under	COBRA:					
□ Yes	□ No	_								
_	COVERAGE INFORM e full name, gender, So	_	lumber and da	ite of birt	h for each pers	on you enro	oll.			
Dependents Cov	erage: st Name	First Name	M.I.	Sex	Social Security		ite of Birth day year	Ad	d/Delete	
Child				□ F □ M						
Child				□F						
Child				□M						
				□M						
Are you or any of	f your enrolled depend	ents covered b	by any other he	ealth insu	rance?	□ Yes □	No			
Name of insured Carrier Name			me	Group Name				Group #		
premiums for the the next plan yea qualified change covered depende ineligible depend	read, and understand to coverage that I have a coverage that I have	elected, if appli at I will not be I understand n riage, divorce, it the Plan may	icable. I unders able to change ny duty to notif or change in s use my perso	stand that my elect y the Un tudent st anal heal	t I am making a tion prior to the iversity within 3 atus. I understa h information fo	a binding ele e next open 31 days of a and that the or the purpo	ection concer enrollment p ny changes t health plan i ses of treatm	rning my medion eriod unless I I that affect the ease not liable to penent, payment,	cal plan benefits for have a eligibility of any of my provide coverage to	
Employee Signature					Date					