US HEALTH AND LIFE INSURANCE COMPANY
C.O.P.S. HEALTH TRUST

_______ Medical
_______ Dental
_______ Vision

ENROLLMENT FORM

_________ NEW _____________ Change/Add

LAST NAME	FIRST NAME	INITIAL

HOME ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NO.	DATE OF BIRTH	TELEPHONE NO.	SEX	MARITAL STATUS:

E-MAIL ADDRESS

ACTIVE __________ RETIRED _______________ OTHER ____________

MARRIED _____
SINGLE _____
DIVORCED _____
WIDOWED _____

NAME OF EMPLOYER	DATE EMPLOYED

NAME OF SPOUSE	SPOUSE SOCIAL SECURITY NO.	EMPLOYER	BIRTH DATE

DEPENDENT'S NAME	RELATIONSHIP	SOCIAL SECURITY #	BIRTH DATE

DEPENDENT'S NAME	RELATIONSHIP	SOCIAL SECURITY #	BIRTH DATE

USE OTHER SIDE FOR ADDITIONAL DEPENDENTS

IF THERE IS ANY OTHER HEALTH INSURANCE COVERAGE PLEASE COMPLETE THE FOLLOWING

Insurance Company: ____

Address: ____________________ City: ____________________ State: ________________

Zip Code: ________________ Phone Number (_____) ____________________ Policy Number: ____________________

CHECK IF ANY FAMILY MEMBER HAS MEDICARE: Yourself _______ Spouse ________ Dependent(s) ________

IF YES, PLEASE ATTACH COPY OF MEDICARE CARD.

____ ____________________

Signature Date Signed

FOR US HEALTH AND LIFE USE ONLY:

Effective Date: __________________ Coverage: ________________________

Group No. ________________ Class No. ________________ PSC Group No. ____________________

Sent to: ________ABS ________PPOM _________HAN

BY: ____

DEPENDENT’S NAME	RELATIONSHIP	SOCIAL SECURITY #	BIRTH DATE
DEPENDENT’S NAME	RELATIONSHIP	SOCIAL SECURITY #	BIRTH DATE
DEPENDENT’S NAME	RELATIONSHIP	SOCIAL SECURITY #	BIRTH DATE
DEPENDENT’S NAME	RELATIONSHIP	SOCIAL SECURITY #	BIRTH DATE