Difference card® Benefit solutions made simple.

Waiving Insurance

Change Insurance

EB EMPLOYEE SOLUTIONS, LLC.

ENROLLMENT FORM

EMPLOYER NAME:

PLAN OPTION (if applicable): Aetna 15

EMPLOYEE INFORMATION

EMPLOYEE NAME (First, Middle, Last):

EMPLOYEE ADDRESS (Line 1):

EMPLOYEE ADDRESS (Line 2):

CITY, STATE, ZIP CODE:	SOCIAL SECURITY NUMBER:*

GENDER:	DATE OF BIRTH (MM/DD/YYYY):	E-MAIL ADDRESS:

DEPENDENT INFORMATION

SPOUSE	FIRST NAME	MIDDLE INITIAL	LAST NAME	
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT? YES ☐ NO ☐	FIRST NAME	MIDDLE INITIAL	LAST NAME	
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT? YES ☐ NO ☐	FIRST NAME	MIDDLE INITIAL	LAST NAME	
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT? YES ☐ NO ☐	FIRST NAME	MIDDLE INITIAL	LAST NAME	
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:
DEPENDENT CHILD FULL TIME STUDENT? YES ☐ NO ☐	FIRST NAME	MIDDLE INITIAL	LAST NAME	
	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:*		GENDER:

I hereby attest to agree to all the terms and conditions in association with the Difference Card. I understand that upon the Difference Card being lost or stolen, I will notify my Human Resource department within 24 hours. Upon termination, I agree to return the difference card within one (1) business day.

EMPLOYEE SIGNATURE

DATE (MM/DD/YYYY):

Due to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110 173), social security numbers must be included or* ***the form will be returned.*

EFFECTIVE DATE (MM/DD/YYYY): August 1, 2017	ACTIVE ☐ COBRA ☐ (please check one)

PLAN OPTION (if applicable): Aetna 15

Donna Davison

APPROVED BY

DATE (MM/DD/YYYY):