

# CORESOURCE

*A Trustmark Company*

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Lancaster, PA 17601  
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TO BE COMPLETED BY EMPLOYER	
DATE OF HIRE	EFFECTIVE DATE
LOCATION #	LOCATION NAME
<input type="checkbox"/> NOTIFICATION & CERTIF. ATTACHED	<input type="checkbox"/> NOTIFICATION & CERTIF. TO FOLLOW
<input type="checkbox"/> NOTIF./CERTIF. ATTACHED <input type="checkbox"/> NO CREDITABLE CVG.	EARNINGS \$ _____ per

## ENROLLMENT APPLICATION

NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH
ADDRESS		
CITY		STATE ZIP
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED	SOCIAL SECURITY NO.

COMPANY NAME <b>Township of Pemberton</b>	Active <input type="checkbox"/>	Retiree <input type="checkbox"/>	GROUP NO. <b>5T</b>
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REHIRE	<input type="checkbox"/> MARRIAGE	<input type="checkbox"/> UNPAID LEAVE OF ABSENCE
<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> ADDRESS CHANGE	<input type="checkbox"/> CHANGE NAME	<input type="checkbox"/> DEPENDENT DEATH
<input type="checkbox"/> ADD NEWBORN	<input type="checkbox"/> ADD CHILD PER COURT ORDER	<input type="checkbox"/> RETIREMENT	<input type="checkbox"/> CHANGE IN EMPLOYMENT STATUS
<input type="checkbox"/> OTHER _____			

LEVEL OF COVERAGE:	INDIVIDUAL ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/ONE CHILD	EMPLOYEE + 2 OR MORE
PLATINUM MEDICAL/DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GOLD MEDICAL/DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SILVER MEDICAL/DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BRONZE MEDICAL/DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DEPENDENT'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	RELATIONSHIP			
				SPOUSE	SON	DGTR	OTHER

**NOTE:** IF THE LAST NAME OF ANY DEPENDENT IS DIFFERENT FROM YOURS, PLEASE EXPLAIN.

I AUTHORIZE MY EMPLOYER TO DEDUCT THE APPROPRIATE CONTRIBUTION FROM MY EARNINGS, IF APPLICABLE. I UNDERSTAND BY COMPLETING AND SIGNING THIS ELECTION FORM, I AM MAKING A BINDING ELECTION FOR THE PLAN YEAR UNLESS I HAVE A QUALIFIED FAMILY STATUS CHANGE DURING THE PLAN YEAR.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I WISH TO WAIVE COVERAGE AT THIS TIME. I UNDERSTAND THAT THIS WAIVER MAY AFFECT COVERAGE TO BE CREDITED TOWARD THE PRE-EXISTING LIMITATIONS IMPOSED ON MY FUTURE PARTICIPATION IN A MEDICAL PLAN. IN ADDITION, I MAY BE RESTRICTED TO ENROLLMENT IN A LATE ENTRANT MEDICAL PLAN.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_