Brown & Brown
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SACHEM CSD - Excess Major Medical/Vision

ENROLLMENT / CHANGE FORM

☐ New Hire Effective Date:	☐ Open Enrollment Effective Date:	☐ Add ☐ Change Enrollment/ Beneficiary Effective Date:	☐ Name Change From _____ To _____
☐ Rehire Effective Date:	☐ Add Spouse and/or Dependent Effective Date: Reason:	☐ Cancel Spouse and/or Dependent Effective Date: Reason:	☐ New Address: _____ _____

Type of Coverage: ☐ Single ☐ Family

A. Employee Information

Last Name	First Name	Middle Initial	Social Security No.

Sex ☐ M ☐ F	Birthdate (MMDDYY)	Street Address / Apt. No

Home Phone	City	State	Zip

Job Title	Date of Employment	Hours Worked Weekly	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

B. Dependent Coverage (If more space is needed, attach extra copies)

Spouse/Partner's Last Name	Spouse/Partner's First Name	Middle Initial		Birthdate (MMDDYY)	Sex
					☐ M ☐ F

Child's Last Name	Child's First Name	Middle Initial		Birthdate (MMDDYY)	Sex	F/T Student
					☐ M ☐ F	☐ Y ☐ N
					☐ M ☐ F	☐ Y ☐ N
					☐ M ☐ F	☐ Y ☐ N
					☐ M ☐ F	☐ Y ☐ N

C. Beneficiaries under EMM (if more space is needed, attach extra copies)

Last Name	First Name	Social Security No.	Benefit %	Relationship
Last Name	First Name	Social Security No.	Benefit %	Relationship
Last Name	First Name	Social Security No.	Benefit %	Relationship
Last Name	First Name	Social Security No.	Benefit %	Relationship

Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay

Last Name	First Name	Social Security No.	Benefit %	Relationship
Last Name	First Name	Social Security No.	Benefit %	Relationship

D. Participation/Waiver

☐ **Request to Participate**: I hereby request the policyholder to arrange the issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions from my earnings as my contributions toward the cost of insurance, if applicable.

☐ **Waiver of Insurance**: I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required to participate in the plan at a later date.

Reason for Refusing: ☐ **Spouse** ☐ **Not Interested** ☐ **Other, please specify:** _____

The information provided above is true and complete to the best of my knowledge and belief.

Employee Signature: _____ **Date:** _____

Employer Representative: _____ **Date:** _____