❒ New Enrollee
❒ Change of Enrollment

CEBT Enrollment / Change Form

Please type or print in ink. ***Employer – Complete all shaded areas at the top of the card.*** ***Employee – Complete non shaded areas.***

Name or employer	Date of Eligibility	Eff. Date (Required)	Salary	Life Volume	Branch #

1. Employee's Name (last, first, middle initial)	2. Social Security #	3.Date of Birth

4. Employee's mailing address Street City State Zip	5. Male ❒ Female ❒

6. Beneficiary's name	6.a. Beneficiary's phone #	7. Relationship to you

6.b. Beneficiary's mailing address Street City State Zip

8.	PPO							EPO				HDHP						DENTAL	VISION	LIFE	DEP	VOL
	2	3	4	5	6	7	8	3	4	5	6	2	3	4	5	28	35				LIFE	LIFE
Employee Only	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐
Employee & Spouse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐			☐
Employee & Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐			☐
Employee & Children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐			☐
Family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐			

Waive coverage	☐	☐		☐	☐

Please access a copy of the new Summary of Benefits and Coverage (SBC) at www.cebt.org.

9. Do you want dependent coverage? yes ❒ no ❒ If yes, complete below and provide proof of legal dependency such as Certificates of birth, marriage, common law, civil union and adoption.

Last, First	Social Security Number (Required)	Date of Birth	Gender	Enrolled in Medicare?
1. Spouse				Y / N
2. Dependent Child				Y / N
3. Dependent Child				Y / N
4. Dependent Child				Y / N
5. Dependent Child				Y / N
6. Dependent Child				Y / N

10. PLEASE CHECK ONE:

Add Spouse ❒ Effective Date _____ Marriage ❒ Drop Spouse ❒ Effective Date _____ Divorce ❒

Add Dependent(s) ❒ Drop Dependent(s) ❒ Beneficiary Change ❒ Name Change ❒ Address Change ❒

I have read and understand the benefits information provided and I am aware that changes may only be made during the annual open enrollment period or if I have a HIPAA qualifying event.

11. Employee's signature _____ Home Phone # _____ 12. Date Signed _____

Email Address _____

2022