

# NBEC Prescription Drug Enrollment Form

New Enrollment
  COBRA
  Change
  Termination

Type of Change \_\_\_\_\_ Effective Date \_\_\_\_\_

**PLEASE PRINT OR TYPE**

Employee Information					
Last Name	First Name	Initial	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Address		City	State	Zip Code	Social Security Number

Coverage Type  Employee Only  Employee and Family

Eligible Dependent Information					
Name (first) Last Name (if different)	Social Security Number	Birth Date	Gender	Other Prescription Coverage?	NBEC Use Only
Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Other Insurance Coverage				
<i>If you or anyone named above answered yes to having other Prescription Drug coverage (i.e., another employer, spouse's employer or a child's natural parent) in the section above, complete the boxes below.</i>				
Name of Insured Person	Social Security Number of Insured	Insured's Birth Date	Is Insured Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group Policy Number of Other Insurance
Name and Address of other Insurance Company		Name and Address of Employer or Policy Holder		Names of Family Members Covered

- I decline all available coverages.
- I hereby certify that I elect coverage as indicated on this form and that all the spouse/dependent information is complete and accurate. If applicable, I authorize my employer to deduct the required premium contributions from my pay.

Employee Signature	Date
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<b>For NBEC Use Only</b>	Entity Name <b>NBEC/NW STATE COM. COLLEGE</b>	Group Number <b>749427</b>	Sub-Group Number <b>A</b>
Verified By _____	Option Number <b>A</b>	Div Number <b>Q50</b>	Effective Date _____

**Please return to your school's treasurer or business office after completion.**