Guardian Enrollment Form
Coahoma Community College/HS
Group # MS 00554038

Effective Date:____________

Location:__________

Please complete the following information.

Social Security #	Last Name	First Name	MI	Date of Birth
				/ /

Home Address	Home Phone #	Sex
	( )	M F

City	State	Zip Code	Business Phone #	
			( )	

List all Eligible Dependents that are to be covered.

	First	Mi	Last	Sex	Date of Birth
Spouse:				M F	/ /
Child:				M F	/ /
Child:				M F	/ /
Child:				M F	/ /
Child:				M F	/ /

Please Circle Your Choice-Monthly Rates

	EE Only	EE+Spouse	EE+Child(ren)	Family
Low Plan	**$21.04**	**$43.71**	**$46.69**	**$68.24**
High Plan	**$27.90**	**$55.81**	**$61.40**	**$89.20**

Status Change Information

Is this a qualifying -Please list qualifying event ________________________________

Add the dependent(s) listed above - Effective date _________/______/________

Delete the dependent(s) listed above - Effective date ________/______/________

Terminate employee coverage Effective date ___________/ ______/__________

Name Change (From) _______________________________ (To) __________________________________

COBRA- Effective date ___________/_________/_____________

Transfer from sub. Loc # _______________ to sub. Loc # _____________ Effective date _______/_____/________

I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X____Date: