

**ENROLLMENT / UPDATE FORM
TRISTAR BENEFIT ADMINISTRATORS (TBA)**

Company: _____ Group No: _____ Loc/Dept: _____ Month/Year: _____

Submitted By: _____ Phone #: _____

NEW EMPLOYEES

Please list each new plan participant. **AN ENROLLMENT FORM MUST BE ATTACHED FOR EACH NEW PARTICIPANT.**

Coverage Effective Date	Last Name	First Name	MI	Social Security Number			Dept / Location	HIPAA Cert (Y / N)

CHANGE IN COVERAGE / ENROLLMENT INFORMATION ⁽²⁾

Please list each employee who is changing any piece of enrollment information (location change, marriage, divorce, new dependent, life volume change, new name, address, etc.) **PLEASE ATTACH AN ENROLLMENT FORM NOTING THE CHANGED INFORMATION.**

Change Effective Date	Last Name	First Name	Social Security Number			Reason for Change (1) (Required)

TERMINATIONS ⁽²⁾

Please report terminations regularly to avoid payment of ineligible claims. Insurance carriers and TBA allow up to three months credit for retroactive terminations.

For COBRA services, provide a list of the benefits elected, along with the current home address, enrolled spouse/dependent names & dates of birth.

Med/Den Plan Term Date	Flex Plan Term Date	Last Pay Date of a Flex Contribution	Last Name	First Name	Social Security Number			Reason for Change ⁽¹⁾ (Required) COBRA Election - List plans (e.g. Medical, Dental) Terminating

⁽¹⁾ Divorce, Death, Loss of Dependent Status, Termination of Employment, COBRA, Voluntary Coverage Termination, etc.
⁽²⁾ Please be advised that if employee premiums are paid pre-tax, the Pre-Tax / Flexible Benefit Plan Document should be consulted for compliance with Federal Section 125 regulations, (e.g. when a person can discontinue enrollment in a plan).