Enrollment and Change Form

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)		Group Name **Tulsa FOP 93 Health and Welfare Trust**	Group Number(s) **144066**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

DISABILITY

Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

Long Term Disability

☒ Employer Paid LTD ☐ Enhanced LTD (Buy-up)

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change Former name ______________________ ☐ Other ________________________

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $______________ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr
0001	**0100**			