Private Health Solutions
CORPORATION

EMPLOYEE Enrollment Form

Company: _____ _____
(Employer) (Agent)

To enroll in the Plan, please complete **Section One** and have your employer complete Section 2

Section One

Employee Name (please print) | Address | Date of Birth

Home Phone Number | Employee Classification (Section C of Application Form)

LISTING OF DEPENDENTS: Please list all of your dependents that will be covered under this Plan. (Attach separate listing if required)

Name of Dependent(s)	Relationship	Birth Date

Dependents of an Eligible Employee are defined as follows:

i. Your spouse, legal or common-law;
ii. Your unmarried children under age 21, or under age 25 if they are full-time students.

Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn age 21, or while they are students under age 25.

I wish to participate in the Employee Health Care Plan and that the information above is correct.

Date: Employee Signature:

Section Two Employer's Approval

I hereby confirm that the employee mentioned above is an eligible employee.

Eligibility Effective Date: Authorized Employer Signature: