



Date: _____

Dear Applicant:

The enclosed application form is being returned to you for the following reason(s):

Section 2: Employee Information

- Social Security Number
- Name/Address Information

Section 3: Type of Activity

- Indicate reason for change(s) requested
- Indicate date of Event(s)

Section 4: Enrollment

- Name, sex, date of birth, social security number and full-time student status for yourself and all dependents that you wish to cover under the insurance plan.

Section 5: Choice of Provider

- HMO and POS Only: Primary Office Number of physician(s) for yourself and all your dependents that you have enrolled under the insurance plan.
- DMO Only: Dentist Office Number for dentist(s) for yourself and all your dependents that you have enrolled under the insurance plan.

Section 6: Other Insurance

- Yes or No to all questions.
- Details of any "Yes" answers.

Section 7: Dependent Information

- Complete this section for any dependents you have enrolled.

Section 9: Employee Signature

- Employee Signature and Date

Please return the completed form(s) promptly. **Delay may result in coverage being denied.** Fax to (714) 953-6987. If you have any questions, please call (866) 358-9456.

Thank you,

Contractor's Choice

A *CHOICE* Administrators Program