CLEAR FORM

PARTICIPANT / EMPLOYER ENROLLMENT FORMS INFO

PARTICIPANT INFORMATION — NEW PARTICIPANT

LAST NAME:_____ FIRST NAME:_____ MI:_____

SSN: _____ MEDICAID#:_____ DOB: _____

MAILING ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHYSICAL ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____ COUNTY: ..Select..

HOME PHONE: _____ CELL: _____

EMAIL ADDRESS: _____

EMPLOYER INFORMATION — CHANGE OF EOR ☐

FEIN: _____ NMTRD#: _____ NMDWS#: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

SSN: _____ DOB: _____

MAILING ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHYSICAL ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____ COUNTY: ..Select..

HOME PHONE: _____ *CELL: _____

*EMAIL ADDRESS: _____

If Employer of Record chooses to "e-Sign" then Employer Email address and Cell Phone Number are REQUIRED.

AGENCY USE ONLY — ☐ E-SIGN ☐ MAIL

PLAN START DATE: _____ UTILIZING VENDORS ONLY: ☐ YES ☐ NO

REQUESTING AGENCY: _____

REQUESTOR'S NAME: _____

REQUESTOR'S EMAIL: _____

DATE SUBMITTED: _____