Blue Cross / Blue Shield

Enrollment and Record Card

Office use only
Effective date

Social Security No. (or Certificate No.)
Can. Social Insurance No.

Your name **(Please print)**
Last | First | Middle initial

☐ Male ☐ Female

Date of birth
Month Day Year

Date employed
Month Day Year

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Clock or Check No.

Occupation

Department

Is dependent coverage desired? ☐ Yes ☐ No

If yes, my dependent coverage is for: ☐ Spouse only ☐ Spouse and children ☐ One child ☐ Two or more children

Spouse's birth date
Month Day Year

Insurance Benefits – According to Plan Employee Life			
Acc. Death & Dismemberment		Weekly Dis. Income Benefit	
Long Term Dis. Mo. Benefit		Medical Care	☐ Employee ☐ Dependent

My Beneficiary: Print **(Example: Mary A. Doe, not Mrs. J. Doe)**
First name | Middle initial | Last name | Relationship

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Contract.

If contributions are required under this Plan, I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential.

CITY OF BERWYN
Employer's name

X
Sign above, Print your resident address below

Date signed