



Wellness Clinic Enrollment Form

Serving Benefits-Eligible 4J Employees, Retirees and Their Dependents

Effective Date: --

Employee #:

Employee Name: _____
(First) (Middle Initial) (Last)

Dependent Information*

Please list dependents who are eligible for the 4J health insurance plan, but not enrolled.

Dependent 1: _____
(First) (Middle Initial) (Last)

Date of Birth: -- SSN:

Relationship: Spouse Partner Child Stepchild Partner's Child Ward

Gender: Male Female

Dependent 2: _____
(First) (Middle Initial) (Last)

Date of Birth: -- SSN:

Relationship: Spouse Partner Child Stepchild Partner's Child Ward

Gender: Male Female

Dependent 3: _____
(First) (Middle Initial) (Last)

Date of Birth: -- SSN:

Relationship: Spouse Partner Child Stepchild Partner's Child Ward

Gender: Male Female

Dependent 4: _____
(First) (Middle Initial) (Last)

Date of Birth: -- SSN:

Relationship: Spouse Partner Child Stepchild Partner's Child Ward

Gender: Male Female

If more than four dependents are to be listed, please submit additional form(s).

X _____
Employee Signature

X _____
Date Signed

*For the definition of benefits-eligible dependent, please visit the OEBC web site:
http://egov.oregon.gov/DAS/OEBC/frequentlyaskedquestions.shtml#Dependent_Eligibility_