

HDHP GROUP HEALTH INSURANCE ENROLLMENT AND PAYROLL DEDUCTION AUTHORIZATION CARD

The University System of Georgia

| | | | | |
|-------------------|--------------|----------------|--------|----------------|
| LAST NAME | FIRST NAME | MIDDLE INITIAL | SEX | BIRTH DATE |
| HOME ADDRESS | | CITY | COUNTY | STATE ZIP CODE |
| SOCIAL SECURITY # | DATE OF HIRE | HOME PHONE | | WORK PHONE |

FAMILY INFORMATION – (only your spouse and dependent children who you wish to be covered should be listed)

| LAST NAME | FIRST NAME | MI | BIRTH DATE | SEX | SOCIAL SECURITY NUMBER | RELATIONSHIP | FULL-TIME STUDENT* |
|-----------|------------|----|------------|-----|------------------------|--------------|--------------------|
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* Additional proof of full-time student status is required for dependent children age 19 - 25

DATE SIGNED _____ SIGNATURE _____ EFFECTIVE DATE _____