CVS CAREMARK PRESCRIPTION PLAN ENROLLMENT FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION

PART 1

Social Security #:	Department:	
Last Name:	Home Address:	
First Name: M.I.	City: State: Zip:	
Date of Hire:	Date of Birth:	Male____ Female____
Effective Date:	Marital Status:	

DEPENDENT INFORMATION:

Name of Spouse: Male___ Female____	Birthdate:
Names of Children: Male___ Female____	Birthdates:
Male___ Female____	
Male___ Female____	
Male___ Female____	

PART 2

STATUS CHANGES:

Date of Marriage:	Other:
Date of Birth:	
Date of Divorce:	

_____ I WISH TO DECLINE PRESCRIPTION COVERAGE AT THIS TIME.
(Please Attach proof of additional coverage.)

_____ _____

EMPLOYEE SIGNATURE DATE