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:

Relation	Change Type	Dependent Name (Last Name, First Name MI)	Gender	Date of Birth
Spouse	☐ Add ☐ Remove		☐ Male ☐ Female	____/____/____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	____/____/____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	____/____/____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	____/____/____
Child	☐ Add ☐ Remove		☐ Male ☐ Female	____/____/____

PART 2

STATUS CHANGES:

Type of Event: ☐ Marriage ☐ Birth ☐ Divorce ☐ Other: _____

Date of Event: ____/____/____

Decline Coverage

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

_____ _____

EMPLOYEE SIGNATURE DATE