PRESCRIPTION BENEFIT PLAN ENROLLMENT FORM

Please fax this form to: (315) 287-7864

Or Mail to ProAct at:
1230 U.S. Highway 11
Gouverneur, NY 13642

EMPLOYER NAME	**Type of Request**	**Type of Change**	**New Add/Change Effective**
	☐ Add	☐ Name	______/______/______
PLAN/DIVISION CODE	☐ Terminate	☐ Address	**Termination Effective Date**
	☐ Change	☐ Spouse	______/______/______
	☐ New Card	☐ Dependant	

Employee SS#			
Employee Last Name	First Name	MI	Employee's Date of Birth
Address		Telephone Number	
City	State	Zip	Sex

List all eligible dependants to be covered in order of age (including spouse)

Relationship	**Full Time Student**	**Last Name (if Different)**	**First Name**	**MI**	**Date of Birth**	**Gender**
Spouse	☐ **YES** ☐ **NO**					
Dependant	☐ **YES** ☐ **NO**					
Dependant	☐ **YES** ☐ **NO**					
Dependant	☐ **YES** ☐ **NO**					

Signature of Employee: ______________________________ Date:__________________

Signature of Authorized Employer Representative: ________________________ Date:____________

For ProAct Use Only

Date Received____________ Date and Time Completed__________________ Cov Code:____

ProAct Representative's Signature ___________________________ HQ Code:________