MARIN BENEFITS ADMINISTRATORS

Enrollment and Change Form

Please complete this form legibly and in its entirety.
Social Security Numbers and date of birth are required for employees and their dependents.
Enrollment Forms without this required information will be returned for completion.

EMPLOYEE INFORMATION				
Employer Name		**Social Security Number**	**Date of Birth**	
First Name	**Last Name**		**Middle Initial**	
Address				
City		**State**	**ZIP**	
Email Address*		**Phone Number***		

**An email address or phone number capable of receiving SMS messages is required to utilize the Marin Benefits online portal*

DEPENDENT INFORMATION				
Last Name	**First Name**	**SSN**	**DOB**	**Relationship**

TO BE COMPLETED BY EMPLOYER					
New Enrollment ☐	**Rehire** ☐	**Termination** ☐	**Address Change** ☐	**Add Dependent(s)** ☐	**Term Dependent(s)** ☐
Other Change? Please describe					
Plan Name and Funding Amount					
Eligibility Date		**Hire Date**		**Termination Date**	
Authorized Signature		**Print Name**		**Date**	

Return this completed form via secure email service to enrollment@marinbenefits.com or fax this form to 415-454-2928