Robert Half®

San Francisco Indemnity Dependent Enrollment Form

Mail or Fax completed form to:

MAIL:
RH HCSO Processing Team
11910 Anderson Mill Rd., Suite 401
Austin, TX 78726

FAX:
1-800-713-0294

Employer Information	
Employer Name **Robert Half**	**Group Number** **FV1386**

Employee Information		
Last Name	**First Name**	**Social Security # or Employee ID**

Benefit Election	
San Francisco Indemnity	**Coverage Tier** ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Dependent Information

Last Name	First Name	Gender	Social Security #	Date of Birth
Spouse		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		

☐ I would like to cover additional eligible dependents (PLEASE LIST ON A SECOND ENROLLMENT FORM)

Employee Agreement

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions, and limitations as outlined by the Plan Sponsor in the issuance of the Plan Summary Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information that is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claims. I agree no benefits will be effective until the date specified at the top of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to Fringe Benefit Group or its designee. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature	Date