BeneCard PBF
Prescription Benefit Facilitator

Enrollment Form

TODAY'S DATE:

CLIENT INFORMATION

Client Name (Plan Sponsor/Employer)	Client #	Group #
CLIENT NAME (PLAN SPONSOR / EMPLOYER)	CLIENT #	GROUP #

CARDMEMBER INFORMATION

John	Quincy	Doe	ID #	123-45-6789
FIRST NAME	MI	LAST NAME	ID #	SSN#

123 Main St. Apt. 1	Anytown	NY	12345
MAILING ADDRESS	CITY	STATE	ZIP CODE

123-456-7890	123-456-7890	personal@email.com
PHONE NUMBER	CELL PHONE	EMAIL

COVERAGE TYPE

PLEASE CHECK ONE:

☑ SINGLE ☐ CARDMEMBER/SPOUSE ☐ CARDMEMBER/CHILD ☐ CARDMEMBER/CHILDREN ☐ FAMILY

EFFECTIVE DATE: 01/01/0001

REASON CODE

A	NEW ENROLLMENT
B	REINSTATE MEMBER
C	REINSTATE DEPENDENT / SPOUSE
D	ADD DEPENDENT / SPOUSE
E	TERMINATE COVERAGE
F	TERMINATE DEPENDENT COVERAGE
G	NAME CHANGE
H	ADDRESS CHANGE
I	GROUP CHANGE: FROM From TO To

J	RDS ENROLLMENT, APPLICATION NUMBER IF APPLICABLE: If RDS
K	ISSUE CARD
L	DO NOT ISSUE ID CARD
M	COBRA ENROLLMENT
N	COBRA TERMINATION
O	STUDENT STATUS UPDATE
P	DISABLED DEPENDENT
Q	OVERAGE DEPENDENT**
R	DEPENDENT ADDRESS DIFFERS FROM CARDMEMBER (INCLUDE ON BACK)

ELIGIBILITY

	LAST NAME	FIRST NAME	MI	GENDER	BIRTHDATE	SSN	HICN	REASON CODES
CARDMEMBER	Doe	John	Qu	Male	01/01/	123-45-6789	1. HICN	1.
02 SPOUSE	2. Last Name	2. First	2.	2.	01/01/	2. SSN	2. HICN	2.
EMAIL/PHONE*	2. Email/Phone*							
03 DEPENDENT	3. Last Name	3. First	3.	3.	01/01/	3. SSN	3. HICN	3.
EMAIL/PHONE*	3. Email/Phone*							
04 DEPENDENT	4. Last Name	4. First	4.	4.	01/01/	4. SSN	4. HICN	4.
EMAIL/PHONE*	4. Email/Phone*							
05 DEPENDENT	5. Last Name	5. First	5.	5.	01/01/	5. SSN	5. HICN	5.
EMAIL/PHONE*	5. Email/Phone*							
06 DEPENDENT	6. Last Name	6. First	6.	6.	01/01/	6. SSN	6. HICN	6.
EMAIL/PHONE*	6. Email/Phone*							
07 DEPENDENT	7. Last Name	7. First	7.	7.	01/01/	7. SSN	7. HICN	7.
EMAIL/PHONE*	7. Email/Phone*							
08 DEPENDENT	8. Last Name	8. First	8.	8.	01/01/	8. SSN	8. HICN	8.
EMAIL/PHONE*	8. Email/Phone*							

*OPTIONAL, ONLY IF DIFFERENT FROM CARMEMBER

COORDINATION OF BENEFITS

Secondary Coverage ID Number	Insurance Company	Policy/Group #
SECONDARY COVERAGE ID NUMBER	INSURANCE COMPANY	POLICY / GROUP#

Employer/Plan Sponsor	01/01/0001
EMPLOYER/PLAN SPONSOR	EFFECTIVE DATE

SIGNATURES

John Doe	John Doe
MEMBER SIGNATURE	CLIENT SIGNATURE

FOR INTERNAL USE ONLY:

DATE ENTERED:_____ ENTERED BY:_____ LOGGED BY:_____

3131 Princeton Pike, Bldg. 2B, Suite 103, Lawrenceville, NJ 08648 Fax: 609-219-1660 eligibility@benecard.com www.benecardpbf.com

Back of Enrollment Form

Dependent Address (1)
(if differs from cardmember)

1. First Name | 1. M.I. | 1. Last Name | 1. ID # | 1. SSN

FIRST NAME | MI | LAST NAME | ID # | SSN

1. Mailing Address

MAILING ADDRESS | CITY | STATE | ZIP CODE

1. Phone Number | 1. Cell Phone | 1. Email

PHONE NUMBER | CELL PHONE | EMAIL

Dependent Address (2)
(if differs from cardmember)

2. First Name | 2. M.I. | 2. Last Name | 2. ID # | 2. SSN

FIRST NAME | MI | LAST NAME | ID # | SSN

2. Mailing Address

MAILING ADDRESS | CITY | STATE | ZIP CODE

2. Phone Number | 2. Cell Phone | 2. Email

PHONE NUMBER | CELL PHONE | EMAIL

Dependent Address (3)
(if differs from cardmember)

3. First Name | 3. M.I. | 3. Last Name | 3. ID # | 3. SSN

FIRST NAME | MI | LAST NAME | ID # | SSN

3. Mailing Address

MAILING ADDRESS | CITY | STATE | ZIP CODE

3. Phone Number | 3. Cell Phone | 3. Email

PHONE NUMBER | CELL PHONE | EMAIL

Dependent Address (4)
(if differs from cardmember)

4. First Name | 4. M.I. | 4. Last Name | 4. ID # | 4. SSN

FIRST NAME | MI | LAST NAME | ID # | SSN

4. Mailing Address

MAILING ADDRESS | CITY | STATE | ZIP CODE

4. Phone Number | 4. Cell Phone | 4. Email

PHONE NUMBER | CELL PHONE | EMAIL

Dependent Address (5)
(if differs from cardmember)

5. First Name | 5. M.I. | 5. Last Name | 5. ID # | 5. SSN

FIRST NAME | MI | LAST NAME | ID # | SSN

5. Mailing Address

MAILING ADDRESS | CITY | STATE | ZIP CODE

5. Phone Number | 5. Cell Phone | 5. Email

PHONE NUMBER | CELL PHONE | EMAIL