Employee Assistance Program (EAP) Enrollment Document

Please fill out this enrollment document to participate in the Employee Assistance Program. Once completed, print this document, sign it, and submit it to your Human Resources representative.

1. Employee Information

Full Name:

Employee ID Number:

Department / Division:

Job Title:

Work Email Address:

Contact Phone Number:

2. Employer Information

Company / Organization Name:

Human Resources Contact Person:

3. Dependent Coverage (Optional)

Please list any eligible household dependents you wish to register for program benefits access:

Dependent 1 (Full Name & Relationship):

Dependent 2 (Full Name & Relationship):

Dependent 3 (Full Name & Relationship):

4. Acknowledgment & Authorization

By signing this document, I acknowledge that I am voluntarily enrolling in the Employee Assistance Program. I understand that the services provided are confidential within the limits of the law and program guidelines.

Employee Signature (Print Name to Sign):

Date (MM/DD/YYYY):