

	EMPLOYMENT STATUS			EFFECTIVE DATE OF COVERAGE/CHANGE		
	<input type="checkbox"/> Active Employee <input type="checkbox"/> Elected Official <input type="checkbox"/> COBRA					
SOC. SEC. #	EMPLOYEE'S LAST NAME			FIRST NAME		MIDDLE INITIAL
MAILING ADDRESS			CITY	STATE	ZIP CODE	HOME PHONE NUMBER
						EMAIL ADDRESS
MARITAL STATUS		GENDER		DATE OF BIRTH		DATE OF FULL TIME HIRE
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MONTH DAY YEAR		HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY)
MEDICAL COVERAGE OPTIONS						
Select one health plan and one coverage level to enroll: <input type="checkbox"/> EPO <input type="checkbox"/> PPO <input type="checkbox"/> PPO BUY-UP <input type="checkbox"/> HDHP** <input type="checkbox"/> Waive Coverage* ENROLL IN HSA? <input type="checkbox"/> Yes** <input type="checkbox"/> No <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family				*Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form **You can only enroll in the HSA if the HDHP is selected. If enrolling in the HSA separate forms are required to be filled out. <i>NOTE: Eligible children include natural, step, adopted, or children for which you have legal guardianship. Please refer to your current Summary Plan Document for full eligibility requirements.</i>		
DENTAL COVERAGE OPTIONS				VISION COVERAGE OPTIONS		
Select one dental plan and one coverage level to enroll: <input type="checkbox"/> Basic Dental (\$2,000 Annual Benefit)* <input type="checkbox"/> Buy-Up Dental (\$4,000 Annual Benefit)** <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> Waive Coverage <i>*Basic Dental Plan – Employee Only Plan. **Buy-Up Dental Plan – Dependent children are eligible up to age 26.</i>				Select one vision plan and one coverage level to enroll: <input type="checkbox"/> Basic Vision* <input type="checkbox"/> Buy-Up Vision** <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> Waive Coverage <i>*Basic Vision Plan – Employee Only Plan. **Buy-Up Vision Plan – Dependent children are eligible up to age 26.</i>		

IMPORTANT: YOU MUST FULLY COMPLETE THE FOLLOWING IF SPOUSE AND/OR DEPENDENT COVERAGE IS BEING REQUESTED

ADD	DEL	NAME	DATE OF BIRTH	SOCIAL SECURITY # (REQUIRED)	RELATION	PLAN
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
						<input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision

OTHER INSURANCE INFORMATION

Do you or your dependents currently have other: Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give name of policyholder and insurance company.
If anyone you are requesting coverage for is currently on Medicare please provide the following:	ID Number _____ Part A Effective Date ____/____/____ Part B Effective Date ____/____/____ Part D Effective Date ____/____/____

AUTHORIZATION AND SIGNATURE

The group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits. I hereby apply for benefits to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the policyholder. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this benefit.

The information provided above is correct to the best of my knowledge. I certify under penalty of perjury that the dependents listed on this form fully meet the listed definition of eligibility. I will provide, if requested, documentation regarding my relationship (marriage or birth certificate, adoption certificate, divorce decree, etc.) to any dependent and his/her age. I will notify my employer within 31 days of a change in my listed dependents eligibility for employer-provided health benefits. I understand that if I do not enroll myself or my dependents, I must read and sign the waiver portion of this form.

 Signature of Employee _____
 Date

WAIVER OF COVERAGE (COMPLETE AND SIGN THIS SECTION IF YOU ARE WAIVING COVERAGE)

Medical/Rx benefits are being waived for (Name) _____ for the following reason(s): _____

- Group benefits available through the group policy of my employer have been explained to me and I understand the scope of the benefits.
- I waive coverage for myself and/or my dependents and elect not to participate.
- I understand that I am waiving this coverage even though my employer may be providing the coverage at little or no cost to me.
- I understand that by waiving enrollment because of other health insurance coverage, I may in the future be able to enroll in this plan, provided that I request enrollment within 31 days after other coverage ends. In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 31 days of the status change.
- I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

 Signature of Employee _____
 Date

TO BE COMPLETED BY HUMAN RESOURCES ONLY

<input type="checkbox"/> New Employee/Rehire	Hire/Rehire Date ____/____/____	Effective Date ____/____/____
<input type="checkbox"/> Add/Delete Dependents	Effective Date of Change ____/____/____	Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Death <input type="checkbox"/> Other
<input type="checkbox"/> Termination of Insurance	Termination Date ____/____/____	Date of Qualifying Event ____/____/____ Name _____
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name/Address Change	HR Dept. Initials _____ Date ____/____/____ Data Input: _____ (HR Initials)