

HEALTH INSURANCE ENROLLMENT FORM

COMPLETED BY ALL FULL TIME TEAM MEMBERS

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY #	DATE OF BIRTH
STREET ADDRESS		APT#	CITY	STATE
GENDER		MARITAL STATUS	HOME PHONE ()	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE		

COMPLETED BY EMPLOYER

AVG. HOURS WORKED PER WEEK	JOB	EARNINGS	<input type="checkbox"/> HOURLY <input type="checkbox"/> YEARLY	DATE OF FT EMPLOYMENT	LOCATION
<input type="checkbox"/> BCBS <input type="checkbox"/> LFG <input type="checkbox"/> BMA <input type="checkbox"/> KRONOS					

PRODUCT SELECTION

TYPE OF COVERAGE	DEPENDENT INFORMATION																																																
BASIC GROUP LIFE/ AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO SHORT TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO LONG TERM DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO DENTAL <input type="checkbox"/> YES <input type="checkbox"/> NO	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;"></td> <td style="width: 10%;">LAST NAME</td> <td style="width: 15%;">FIRST NAME</td> <td style="width: 10%;">GENDER</td> <td style="width: 10%;">DOB</td> <td style="width: 15%;">SS#</td> </tr> <tr> <td colspan="6">SPOUSE</td> </tr> <tr> <td colspan="6">CHILDREN</td> </tr> <tr><td colspan="6"> </td></tr> <tr><td colspan="6"> </td></tr> <tr><td colspan="6"> </td></tr> <tr><td colspan="6"> </td></tr> <tr><td colspan="6"> </td></tr> </table>		LAST NAME	FIRST NAME	GENDER	DOB	SS#	SPOUSE						CHILDREN																																			
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CHILDREN																																																	
<div style="border: 1px solid black; padding: 2px; font-size: small;"> ** ALL FULL TIME EMPLOYEES MUST ELECT BASIC GROUP LIFE/ AD&D, SHORT TERM & LONG TERM DISABILITY EVEN IF DECLINING MEDICAL COVERAGE. </div>	<input type="checkbox"/> EMP ONLY <input type="checkbox"/> EMP + SPOUSE <input type="checkbox"/> EMP + CHILDREN <input type="checkbox"/> EMP + FAMILY																																																

MEDICAL	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EMP ONLY <input type="checkbox"/> EMP + SPOUSE <input type="checkbox"/> EMP + CHILDREN <input type="checkbox"/> EMP + FAMILY	SPOUSE	CHILDREN	LAST NAME	FIRST NAME	GENDER	DOB	SS#

BENEFICIARY INFORMATION All Full Time Team Members must complete this information

PRIMARY BENEFICIARY					
*LAST NAME	*FIRST	MI	*RELATIONSHIP	SOCIAL SECURITY #	
*STREET ADDRESS			*CITY	*STATE	*ZIP
*required information					

CONTINGENT BENEFICIARY					
LAST NAME	FIRST	MI	RELATIONSHIP	SOCIAL SECURITY #	
STREET ADDRESS			CITY	STATE	ZIP

WAIVER	I Decline to enroll for Dental coverage for myself, my spouse, and my dependent children due to: <input type="checkbox"/> Existence of other health coverage <input type="checkbox"/> Spousal Coverage <input type="checkbox"/> Other (explain) _____
	I Decline to enroll for Medical coverage for myself, my spouse, and my dependent children due to: <input type="checkbox"/> Existence of other health coverage <input type="checkbox"/> Spousal Coverage <input type="checkbox"/> Other (explain) _____
Check one of the above boxes, then read & sign	

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and must meet the requirements defined in the enrollment section of the Certificate of Coverage, and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption or party in suit of adoption.

X Employee Signature _____ **Date** _____
(only sign if you are waiving coverage)

SIGNATURE

I confirm that the information I have provided on this form is complete and accurate. I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand that there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

X Employee Signature _____ **Date** _____