# 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 | ZIP

GENDER ☐ MALE ☐ FEMALE | MARITAL STATUS ☐ MARRIED ☐ SINGLE | HOME PHONE ( )

## COMPLETED BY EMPLOYER

AVG. HOURS WORKED PER WEEK | JOB | EARNINGS ☐HOURLY ☐YEARLY | DATE OF FT EMPLOYMENT | LOCATION

**☐ BCBS ☐ LFG ☐ BMA ☐ KRONOS**

## PRODUCT SELECTION

TYPE OF COVERAGE

| | | |
|---|---|---|
| BASIC GROUP LIFE/ AD&D | ☐ YES | ☐ NO |
| SHORT TERM DISABILITY | ☐ YES | ☐ NO |
| LONG TERM DISABILITY | ☐ YES | ☐ NO |
| DENTAL | ☐ YES | ☐ NO |

☐ EMP ONLY
☐ EMP + SPOUSE
☐ EMP + CHILDREN
☐ EMP + FAMILY

** ALL FULL TIME EMPLOYEES MUST ELECT BASIC GROUP LIFE/ AD&D, SHORT TERM & LONG TERM DISABILITY EVEN IF DECLINING MEDICAL COVERAGE.

DEPENDENT INFORMATION

| | *LAST NAME* | *FIRST NAME* | *GENDER* | *DOB* | *SS#* |
|---|---|---|---|---|---|
| SPOUSE | | | | | |
| CHILDREN | | | | | |

**MEDICAL** ☐ YES ☐ NO

☐ EMP ONLY
☐ EMP + SPOUSE
☐ EMP + CHILDREN
☐ EMP + FAMILY

| | *LAST NAME* | *FIRST NAME* | *GENDER* | *DOB* | *SS#* |
|---|---|---|---|---|---|
| SPOUSE | | | | | |
| CHILDREN | | | | | |

## 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:**

☐ Existence of other health coverage ☐ Spousal Coverage ☐Other (explain)

**I Decline to enroll for Medical coverage for myself, my spouse, and my dependent children due to:**

☐ Existence of other health coverage ☐ Spousal Coverage ☐ 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** ______________