PHSD- Enrollment Form

Effective Date: _____ **Hire Date:** _____

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married

ADDRESS	CITY	STATE	ZIP

Coverage Type	Election	Coverage Level
Medical/RX (Highmark - Performance Blue Flex)	☐ **EPO** ☐ **PPO**	☐ Individual ☐ Parent/Child ☐ Parent/Children ☐ Employee/Spouse ☐ Family
Vision (Davis)	☐	☐ Individual ☐ Family
Dental: Contributory (Cigna)	☐	☐ Individual ☐ Family
Dental: Non-Contributory (Cigna)	☐	☐ Individual ☐ Family

Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. Any time a qualifying life event occurs, the employee needs to inform Human Resources within 30 days of occurrence in order to make a change to coverage.

☐ I am opting out of all coverages. By checking this box, I understand that I will not be enrolled in any of the above coverages.

Dependent Election

	NAME	SSN	DATE OF BIRTH	GENDER	RELATIONSHIP	Medical/RX	Dental	Vision
1						☐	☐	☐
2						☐	☐	☐
3						☐	☐	☐
4						☐	☐	☐

Enrollment Attestation

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled.

_____	_____	_____	_____
Authorized Employer Signature	Date	Employee Signature	Date