



TO BE COMPLETED BY EMPLOYER	
DATE OF HIRE	EFFECTIVE DATE
LOCATION #	LOCATION NAME

### BENEFIT ENROLLMENT APPLICATION

NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH
ADDRESS		
CITY		STATE ZIP
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED	SOCIAL SECURITY NO.

COMPANY NAME	GROUP NO.
<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REHIRE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> UNPAID LEAVE OF ABSENCE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> CHANGE NAME <input type="checkbox"/> DEPENDENT DEATH <input type="checkbox"/> ADD NEWBORN <input type="checkbox"/> ADD CHILD PER COURT ORDER <input type="checkbox"/> RETIREMENT <input type="checkbox"/> CHANGE IN EMPLOYMENT STATUS <input type="checkbox"/> REMOVE DEPENDENT (Reason) _____ <input type="checkbox"/> OTHER _____	

LEVEL OF COVERAGE: MEDICAL	<input type="checkbox"/> EE ONLY	<input type="checkbox"/> EE/SPOUSE	<input type="checkbox"/> EE/CHILD	<input type="checkbox"/> EE/CHILDREN	<input type="checkbox"/> FAMILY
LEVEL OF COVERAGE: DENTAL	<input type="checkbox"/> EE ONLY	<input type="checkbox"/> EE/SPOUSE	<input type="checkbox"/> EE/CHILD	<input type="checkbox"/> EE/CHILDREN	<input type="checkbox"/> FAMILY
LEVEL OF COVERAGE: VISION	<input type="checkbox"/> EE ONLY	<input type="checkbox"/> EE/SPOUSE	<input type="checkbox"/> EE/CHILD	<input type="checkbox"/> EE/CHILDREN	<input type="checkbox"/> FAMILY

DEPENDENT'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	RELATIONSHIP			
				SPOUSE	SON	DGTR	OTHER

**NOTE:** IF THE LAST NAME OF ANY DEPENDENT IS DIFFERENT FROM YOURS, PLEASE EXPLAIN RELATIONSHIP:

**OTHER INSURANCE:** Are you or any of your eligible dependents covered by any other Medical plan? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If yes, please provide other Medical plan information.

Name of Insured	Effective Date	Insurance Company	Group or Policy Number

**MEDICARE INSURANCE: Are you or any of your eligible dependents covered by Medicare? \_\_\_\_\_ YES \_\_\_\_\_ NO**  
**If yes, please provide Medicare information.**

Name of Insured	Effective Date Part A & B	Medicare Claim Number	Reason: Age or Disabled or ESRD

I AUTHORIZE MY EMPLOYER TO DEDUCT THE APPROPRIATE CONTRIBUTION FROM MY PRE-TAX EARNINGS, IF APPLICABLE. I UNDERSTAND BY COMPLETING AND SIGNING THIS ELECTION FORM, I AM MAKING A BINDING ELECTION FOR THE PLAN YEAR UNLESS I HAVE A QUALIFIED FAMILY STATUS CHANGE DURING THE PLAN YEAR.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_

I WISH TO WAIVE COVERAGE AT THIS TIME.

PLEASE NOTE YOU MAY NOT CHANGE BENEFIT ELECTIONS UNTIL THE NEXT OPEN ENROLLMENT UNLESS YOU HAVE A QUALIFYING EVENT IN EMPLOYMENT OR FAMILY STATUS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_