

	<b>EMPLOYMENT STATUS</b>	<b>EFFECTIVE DATE OF COVERAGE/CHANGE</b>	
	<input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA		
<b>SOC. SEC. #</b>	<b>EMPLOYEE'S LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>

<b>MAILING ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	<b>HOME PHONE NUMBER</b>	<b>EMAIL ADDRESS</b>

<b>MARITAL STATUS</b>	<b>GENDER</b>	<b>DATE OF BIRTH</b>	<b>DATE OF FULL TIME HIRE</b>	<b>HOURS WORKED PER WEEK (ACTIVE EMPLOYEES ONLY)</b>
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<small>MONTH DAY YEAR</small>		

**MEDICAL COVERAGE OPTIONS**

<p style="text-align: center;"><b>Select one health plan and one coverage level to enroll:</b></p> <p style="text-align: center;"> <input type="checkbox"/> PPO    <input type="checkbox"/> PPO BUY-UP    <input type="checkbox"/> HDHP    <input type="checkbox"/> Waive Coverage*         </p> <p style="text-align: center;"> <b>ENROLL IN HSA?</b>    <input type="checkbox"/> Yes**    <input type="checkbox"/> No         </p> <p style="text-align: center;"> <input type="checkbox"/> Employee    <input type="checkbox"/> Employee + Spouse    <input type="checkbox"/> Employee + Child(ren)    <input type="checkbox"/> Employee + Family         </p>	<p style="text-align: center;">*Employees waiving coverage must complete the Waiver of Coverage located on Page 2 of this Benefit Enrollment/Change Form</p> <p style="text-align: center;">**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.</p> <p style="text-align: center;"><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></p>
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<b>DENTAL COVERAGE OPTIONS</b>	<b>VISION COVERAGE OPTIONS</b>
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<p style="text-align: center;"><b>Select one dental plan and one coverage level to enroll:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Basic Dental (\$2,000 Annual Benefit)*    <input type="checkbox"/> Buy-Up Dental (\$4,000 Annual Benefit)**         </p> <p style="text-align: center;"> <input type="checkbox"/> Employee    <input type="checkbox"/> Employee + Spouse    <input type="checkbox"/> Employee + Child(ren)    <input type="checkbox"/> Employee + Family         </p> <p style="text-align: center;"> <input type="checkbox"/> Waive Coverage         </p> <p style="font-size: small;">*Basic Dental Plan – Dependent children are eligible up to age 19 only.          **Buy-Up Dental Plan – Dependent children are eligible up to age 26.</p>	<p style="text-align: center;"><b>Select one vision plan and one coverage level to enroll:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Basic Vision*    <input type="checkbox"/> Buy-Up Vision**         </p> <p style="text-align: center;"> <input type="checkbox"/> Employee    <input type="checkbox"/> Employee + Spouse    <input type="checkbox"/> Employee + Child(ren)    <input type="checkbox"/> Employee + Family         </p> <p style="text-align: center;"> <input type="checkbox"/> Waive Coverage         </p> <p style="font-size: small;">*Basic Vision Plan – Dependent children are eligible up to age 19 only.          **Buy-Up Vision Plan – Dependent children are eligible up to age 26.</p>
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**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 _____/_____/_____	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name/Address Change	HR Dept. Initials _____    Date _____/_____/_____    Data Input: _____ (HR Initials)