EMPLOYEE BENEFITS ELECTION FORM

TYPE OF CHANGE, CHECK ONE:

◯ OPEN ENROLLMENT CHANGE ◯ OPEN ENROLLMENT– NO CHANGES ◯ NEW HIRE ◯ MID-YEAR QUALIFYING EVENT

EMPLOYEE INFORMATION Date of Qualifying Event:

NAME:_____ DATE OF HIRE:_____

ADDRESS: _____

PHONE:_____ EMAIL:_____

GENDER: _____ DATE OF BIRTH_____ SSN:_____

SALARY_____ OCCUPATION:_____

MEDICAL COVERAGE				
PLAN OPTIONS	**EMPLOYEE**	**EMPLOYEE + SPOUSE**	**EMPLOYEE + CHILD(REN)**	**FAMILY**
☐ WAIVE MEDICAL COVERAGE				

*Complete HMO PCP section if selecting the HMO plan (see last page)

ANCILLARY COVERAGES

DENTAL PPO		
	TIER	**Weekly Premium**
☐	Employee	
☐	Employee + Spouse	
☐	Employee + Child(ren)	
☐	Family	
☐	WAIVE DENTAL	

VISION		
	TIER	**Weekly Premium**
☐	Employee	
☐	Employee + Spouse	
☐	Employee + Child(ren)	
☐	Family	
☐	WAIVE VISION	

VOLUNTARY LIFE & AD&D INSURANCE

I elect to purchase additional employee paid life/AD&D insurance. Please complete separate application for any amount over Guarantee Issue._____

Employee Amount $ _____

Spouse Amount $ _____

Child(ren) Amount $ _____

I waive additional employee paid life/AD&D insurance.

VOLUNTARY LIFE INSURANCE BENEFICIARY INFORMATION			
NAME	**ADDREESS**	**%**	**RELATIONSHIP**

SHORT & LONG-TERM DISABILITY INSURANCE

I elect employer-paid Short & Long-term disability

I hereby certify that the above information is complete and accurate.

Employee Signature: _____ Date: _____._____

DEPENDENT INFORMATION					
DEPENDENT NAME	**RELATIONSHIP**	**GENDER**	**MEDICAL**	**DENTAL**	**VISION**

HMO PCP PROVIDER INFORMATION			
MEMBER NAME	**PROVIDER NAME**	**PCP ID**	**MEDICAL GROUP NUMBER**

GROUP SPONSORED LIFE INSURANCE

I elect employer-paid Short & Long-term disability