2023 Benefit Enrollment Form

EMPLOYER USE ONLY (CHECK ONE) TYPE OF REQUEST: ❑ NEW ❑ INFORMATION CHANGE ❑ STATUS CHANGE ❑ OPEN ENROLLMENT EFFECTIVE DATE: _____/_____/_____	DATE HIRED: _____/_____/_____

PERSONAL INFORMATION:

SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME: FIRST	MI	LAST		
ADDRESS:	CITY:			STATE:	ZIP:
JOB TITLE:	HOME PHONE: ( )	WORK PHONE: ( )	DATE OF BIRTH: _____/_____/_____		SEX: ❑ F ❑ M
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW(ER) DATE OCCURRED: _____/_____/_____	E-MAIL ADDRESS: ❑ By checking this box and providing my E-mail address above, I consent to receive Plan documents and all related Plan communications electronically. I understand that I am able to revoke this authorization by writing the Plan Administrator.: _____.				

COVERAGE SELECTION: **I WOULD LIKE TO ENROLL IN COVERAGE AS FOLLOWS.** PLEASE CHECK THE APPROPRIATE COVERAGE. IF YOU ARE NOT ELECTING COVERAGE, YOU MUST CHECK THE WAIVE BOX

	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY	WAIVE*
DENTAL ❑ Delta Dental	❑	❑	❑	❑	❑
VISION ❑ VSP	❑	❑	❑	❑	❑

PARTICIPANT INFORMATION:

NAME (First, MI, Last)	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VISION	BIRTH DATE	SEX	DISABLED Y/N
EMPLOYEE:		❑	❑	❑	_____/_____/_____		
SPOUSE:		❑	❑	❑	_____/_____/_____		
DEPENDENT:		❑	❑	❑	_____/_____/_____		
DEPENDENT:		❑	❑	❑	_____/_____/_____		
DEPENDENT:		❑	❑	❑	_____/_____/_____		
DEPENDENT:		❑	❑	❑	_____/_____/_____		
DEPENDENT:		❑	❑	❑	_____/_____/_____		

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***WAIVER:** I waive my right to one or more of the coverages by electing "WAIVE" at this time.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS: If you are declining enrollment in the Medical component of the plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days of your other coverage ending. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.

EMPLOYEE AUTHORIZATION: I hereby request coverage for myself and my eligible dependents, and authorize my employer to deduct from my earnings the amount required to participate in the elected benefits. I understand that certain payroll deductions will be made on a pre-tax basis. I further understand that these benefits will remain in effect and cannot be changed or revoked unless the change is on account of and consistent with a Status Change or until an affirmative election is made during a subsequent open enrollment period. I have carefully read this enrollment form and agree to its terms. The information on this enrollment form will form the basis for the insurance applied for. I understand that the insurance is not in force until approved by the insurance carrier(s). THIS IS AN ENROLLMENT FORM NOT AN APPLICATION FOR INSURANCE. If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a human resources representative before signing this enrollment form.

EMPLOYEE SIGNATURE: _____ DATE: _____