ENROLLMENT OF GROUP BENEFITS

Benefit Health Plan, Inc
ADMINISTRATORS

EMPLOYER:		EFFECTIVE DATE:	
LOCATION:			

EMPLOYEE LAST NAME	FIRST NAME	MI	DOB (mm/dd/yy)	SOCIAL SECURITY NUMBER

EMPLOYEE MAILING ADDRESS	STREET	APT#	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE	GENGER	
		□ M	□ F

MEDICAL COVERAGE TYPE ELECTED	MARITAL STATUS
□ SINGLE □ SPOUSE □ CHILD □ CHILDREN □ FAMILY	□ MARRIED □ SINGLE □ DIVORCED □ OTHER

□ I AM WAIVING MEDICAL COVERAGE AND UNDERSTAND THE OPTION TO ADD
COVERAGE MAY NOT BE AVAILABLE UNTIL THE NEXT OPEN OR SPECIAL ENROLLMENT PERIOD.

DEPENDENTS:

	LAST NAME	FIRST NAME	GENDER		DOB (mm/dd/yy)	SOCIAL SECURITY NUMBER
SPOUSE:						
CHILD:						
CHILD:						
CHILD:						
CHILD:						
CHILD:						

PLAN ELECTION:

PLEASE CHECK ONE OPTION:		DEDUCTIBLE LEVEL	CHECK NETWORK BOX:	
VISIT LIMIT		CHOICE OF: □$1,000 □$1,650	PHCS □	Anthem □
MAJOR MEDICAL		CHOICE OF: □$3,500 □$4,500	PHCS □	Cigna □
HSA MAJOR MEDICAL		CHOICE OF: □$3,500 HSA □$8,300 HSA	PHCS □	Cigna □

OTHER COVERAGE INFORMATION

DO YOU OR YOUR DEPENDENTS HAVE OTHER MEDICAL COVERAGE UNDER ANOTHER HEALTH PLAN SUCH AS AN EMPLOYER SPONSORED GROUP HEALTH PLAN OR HMO, INDIVIDUAL POLICY, MEDICARE, MEDICAID OR CHAMPUS? □YES □ NO

IF YES, PLEASE PROVIDE:

CARRIER		EFFECTIVE DATE		GROUP #	

AUTHORIZATION

I HEREBY REQUEST COVERAGE UNDER THE GROUP POLICY(IES) ISSUED BY MY EMPLOYER'S HEALTH PLAN.
I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS.
I AM AN ELIGIBLE EMPLOYEE MEETING THE REQUIREMENTS OF PARTICIPATION WITH MY EMPLOYER. I UNDERSTAND THAT MY ELECTION OF COVERAGES ABOVE DOES NOT AUTOMATICALLY GUARANTEE THAT COVERAGE IS IN FORCE. ALL ELIGIBILITY REQUIREMENTS OF THE POLICY(IES) MUST BE PROPERLY SATISFIED BEFORE COVERAGE BECOMES EFFECTIVE AND TO REMAIN ACTIVE.

EMPLOYEES SIGNATURE:	DATE
(REQUIRED)	(REQUIRED)

ADDITIONAL BENEFIT COVERAGE ELECTIONS:

HSA EMPLOYEE CONTRIBUTION (if participating in HSA qualified option):

I WISH TO CONTRIBUTE TO MY HSA ACCOUNT : □ YES □ NO $ _____ /MONTH (PRE-TAX SALARY CONTRIBUTION)

DENTAL COVERAGE TYPE ELECTED	DENTAL PLAN OPTION:
□ SINGLE □ SPOUSE □ CHILD □ CHILDREN □ FAMILY	□ SMART PREMIUM □ SMART PREMIUM PLUS
VISION COVERAGE TYPE ELECTED	VISION PLAN OPTION:
□ SINGLE □ SPOUSE □ CHILD □ CHILDREN □ FAMILY	□ CHOICE PLAN

EMPLOYEE LIFE INSURANCE		DEPENDENT LIFE INSURANCE	
LIFE CLASS/AMOUNT:		LIFE AMOUNT	
ADDITIONAL LIFE AMOUNT:		ADDITIONAL LIFE:	

BENEFICIARY LAST NAME	FIRST NAME	MIDDLE IN	DOB (mm/dd/yy)	RELATIONSHIP	%