ENROLLMENT OF GROUP BENEFITS

XGB | X GROUP BENEFITS

EMPLOYER: | EFFECTIVE DATE:

LOCATION:

EMPLOYEE LAST NAME:	FIRST NAME:	MI:	DOB: (MM/DD/YY)	SOCIAL SECURITY NUMBER:

EMPLOYEE MAILING ADDRESS: STREET:	APT#:	CITY:	STATE:	ZIPCODE:

EMAIL ADDRESS:	PHONE:	GENDER:
		☐ M ☐ F

MEDICAL COVERAGE TYPE ELECTED: | MARTIAL 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.

Waive Reason: ☐ Medicare ☐ Medicaid ☐ Spousal Coverage ☐ Parents Coverage ☐ Tricare ☐ Tribal ☐ Other

DEPENDENTS:

	LAST NAME	FIRST NAME	GENDER	DOB (MM/DD/YY)	SOCIAL SECURITY NUMBER
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					

PLAN ELECTION: | CHECK NETWORK BOX:

PLEASE CHECK ONE OPTION: DEDUCTIBLE LEVEL:

VISIT LIMIT:	**CHOICE OF:** ☐ **$1,000** ☐ $1,750 HSA	☐ **PHCS**	
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) ISSUES 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:

(REQUIRED)

DATE:

(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: **NOT AVAILABLE AT THIS TIME
LIFE CLASS/AMOUNT:	☐ $20K ☐ $200K	LIFE AMOUNT:
ADDITIONAL LIFE AMOUNT:		ADDITIONAL LIFE:

BENEFICIARY LAST NAME:	FIRST NAME:	MIDDLE IN:	DOB (MM/DD/YY):	RELATIONSHIP:	%:

SUPPLEMENTAL PLAN:

☐ EE ☐ ES ☐ EC ☐ FAM