

ENROLLMENT OF 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.										
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 \$1,650 HSA		PHCS BCBS		
MAJOR MEDICAL:				CHOICE OF:		\$3,500 \$4,500		PHCS CIGNA BCBS		
HSA MAJOR MEDICAL:				CHOICE OF:		\$3,500 HSA \$8,300 HSA		PHCS CIGNA BCBS		
EPO:				CHOICE OF:		\$1,000 \$1,650 HSA		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: **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							