| To Be Completed by Employer | |
|---|---|
| Effective date for benefits: _____/_____/______ | |
| Date of full-time employment: ______/_____/______ | |
| Salary per $_______________ ☐ hour ☐ year | |
| Occupation: ___________________ | Class: __________ |
| Location/Division: ______________________________ | |

# Benefit Plan Enrollment Form

## Part I: ENROLLMENT EVENT

| Select Enrollment Event Below | |
|---|---|
| ☐ Open Enrollment ☐ New Hire ☐ New Enrollment | ☐ Cancel Employee ☐ Cancel Dependent |
| ☐ Change due to Qualifying Event: Event Date: ____/_____/______<br>Description of Change: *Supporting documentation is required<br>☐ Marriage ☐ Birth or Adoption ☐ Court Order ☐ Loss of other coverage<br>☐ Other: ________________________ | Reason:___________________________________<br>*Select dependent(s) cancelling in Part 4 below<br>Event Date: _____/_____/_______ |

## Part II: EMPLOYEE INFORMATION

| All Information is Required | | | |
|---|---|---|---|
| Employee (First, MI, Last) | Date of Birth | Social Security No. | Gender<br>☐ Male ☐ Female |
| Home Address | | E-Mail Address | |
| City | State | Zip | Marital Status<br>☐ Single ☐ Married ☐ Widowed ☐ Divorced |
| Home Phone | Work Phone | Medicare Coverage<br>☐ None ☐ Part A ☐ Part B | Medicare Effective Date |

## Part III: SELECT YOUR COVERAGE

| Medical Election<br>BCBS - BlueChoice $1,000 Ded |
|---|
| ☐ Employee Only<br>☐ Employee & Spouse<br>☐ Employee & Child(ren)<br>☐ Employee & Family<br>☐ Decline<br>☐ No Change |

## Part IV: COMPLETE DEPENDENT DETAILS

All Information is Required for **ALL** Plan Elections. ***Dependents without complete information will not get coverage.***

| Name (First, MI., Last) | Date of Birth | Social Security Number | Gender | Relationship | Circle One: | Dependent Disabled? | Circle Benefit Elected for Each Participant |
|---|---|---|---|---|---|---|---|
| | | | | | ADD DROP CHANGE | ☐ Yes ☐ No | ☐ Medical |
| | | | | | ADD DROP CHANGE | ☐ Yes ☐ No | ☐ Medical |
| | | | | | ADD DROP CHANGE | ☐ Yes ☐ No | ☐ Medical |
| | | | | | ADD DROP CHANGE | ☐ Yes ☐ No | ☐ Medical |
| | | | | | ADD DROP CHANGE | ☐ Yes ☐ No | ☐ Medical |

## Part V: OTHER MEDICAL COVERAGE INFORMATION

All Information is Required

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including Medicare that will continue even when on employer's coverage? ☐ Yes (continue completing this section) ☐ No Name of other carrier__________________________________ Health Group No. ___________________

| Other Group Medical Coverage Information | Effective Date | Name & date of birth of policy holder for other coverage |
|---|---|---|
| Employee | | |
| Spouse Name | | |
| Dependent Name | | |
| Dependent Name | | |
| Dependent Name | | |

## Part VI: GROUP MEDICAL BENEFITS REFUSAL

Complete if you and/or your dependents are refusing the group medical plan

This is to certify that I have been given the opportunity to examine the group medical benefits available to me and to apply through my employer, and I have decided NOT to apply for group benefits for ☐ myself ☐ my dependents.

| Declining Insurance Due To: ☐ Spouse's Employer Plan ☐ Covered by Medicare ☐ Individual Plan ☐ Other: ______________________________ | Carrier/Employer |
|---|---|

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you have be able to enroll yourself and your dependents as outlined in the plan, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

| Employee Signature for Refusal | Date |
|---|---|

## Part VII: ENROLLMENT SIGNATURE & CERTIFICATION

Signature is required for acceptance of group benefits

I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amounts will change if my coverage or costs change.

All premiums for medical and vision are withheld pre-tax unless otherwise indicated.

| Employee Signature | Date |
|---|---|