GROUP INSURANCE ENROLLMENT/CHANGE FORM 2016/2017
LOCATION:

EMPLOYEE INFORMATION: ***Effective Date:***

Name:	SSN:	
Address:		
Telephone:	Marital status:	DOB:

Benefit Plan	**Weekly Cost**				
	Single	**Employee/Spouse**	**Emp/Child(ren)**	**Family**	**Decline**
Medical	☐ $35.09	☐ $177.74	☐ $144.70	☐ $289.05	☐ Decline
Dental- Delta	☐ $1.59	☐ $6.89	☐ $10.35	☐ $15.27	☐ Decline
Vision- PEP	☐ $1.82	☐ $3.83	☐ $3.83	☐ $5.63	☐ Decline

Additional Life Ins Maximum of $500,000. Guarantee issue amount of $150,000 in increments of $1,000.	☐ 10k	☐ 20k	☐ 30k	☐ 40k	☐ 50k	☐ 60k	☐ 70k	☐ 80k	☐ 90k	☐ 100k	☐ 110k	☐ 120k	☐ 130k	☐ 140k	☐ 150k	Other	☐ Decline

Spouse Additional Life I available in increments of $5000 guarantee issue amount, $25,000.	☐ $10k	☐ $15k	☐ $20k	☐ $25k	Other	☐ Decline
Dependent Additional Life Ins.(rate is for all children)	☐ $5,000		☐ $10,000		Other	☐ Decline

MY BENEFIT ELECTION IS (CHECK √ YOUR CHOICE(S) :

If you would like to keep your benefit elections the same for the 2016/2017 plan year then check this box:☐

Flex Benefit Elections	
I wish to participate in this account for 2016/2017 ☐ Flex Spending ☐ Dependent Care	
Medical/Dental/Vision Spending Election (maximum election $2550)	Annual Election: $
Dependent Care Election (IRS maximum allowable election $2500 single, $5000 family)	Election Amount: $

Please provide covered dependent information for any dependent elections above on back of this form.

Are you, your spouse or your dependents covered by any insurance other than that mentioned above: Yes ☐ No ☐
If yes, please enter the name of the person covered and the name and address of the insurance company:_____
_____

AGREEMENT FOR MEDICAL AND/OR DENTAL AND/OR LIFE INSURANCE COVERAGE:

My signature below indicates that I have chosen voluntarily the type of coverage that I believe is most appropriate for my eligible dependents and me. I understand that the company does not recommend, endorse or guarantee the quality of care or service that is provided. I understand that my enrollment selection will become effective on the Effective Date shown above. I also understand that I have the option to change plans only once each year during the annual open enrollment, which will be held in September 2017. I hereby authorize the company, to deduct from my pay the amount determined. To apply towards the monthly premium for my choice of coverage's elected above. I hereby certify the above information is correct.

_____ _____
EMPLOYEE SIGNATURE DATE SIGNED

COVERAGE'S ACCEPTING_____

Dependent must be recorded on reverse side

Request For Change Section

ENROLLMENT CHANGE REQUESTED:

_____**Add Dependent** _____**Drop Dependent** _____Add Employee Coverage _____Drop Employee Coverage

Reason for Change (Qualifying Event):

_____ Marriage _____ Birth/Adoption _____Termination

_____ Divorce _____ Death _____ Other

Medical Covered Dependents: Please list below the dependent you are adding or dropping.

Name	Relationship	Sex	Birth Date	College Student?	SSN #

Dental Covered Dependents: Please list below the dependents you are adding or dropping

Name	Relationship	Sex	Birth Date	College Student?	SSN #

Vision Covered Dependents: Please list below the dependents your are adding or dropping

Name	Relationship	Sex	Birth Date	College Student?	SSN #

LIFE INSURANCE BENEFICIARY

Primary

Name:	Relationship:	SSN:	Percentage:
Name:	Relationship:	SSN:	Percentage:

Contingent

Name:	Relationship:	SSN:	Percentage:
Name:	Relationship:	SSN:	Percentage: