GROUP INSURANCE ENROLLMENT/CHANGE FORM 2018



EMPLOYEE INFORMATION:

EMPLOYEE INFORMATION:			Effective Date:
Name:		SSN:	
Address:			
Telephone:	Marital status:		DOB:

Benefit Plan		Bi-Weekly Cost												
		Single	•	Em	Employee/Spouse Emp/Children Fa							Family	Decline	
Medical- HDHP		\$6.00)		□ \$21	9.23	3 🗆 \$152.31 🗆 \$				\$343.85	□ Decline		
Medical- Silver Plan		\$30.9	92		□ \$26	8.15	5 🛛 \$193.38					\$406.15	□ Decline	
Medical- Gold Plan		\$55.8	35		□ \$317.08			3 □ \$234.46				□ \$468.92		□ Decline
Dental- Delta		\$0.00)		□ \$15.91 □ \$21.22 □				\$42.56	□ Decline				
Vision- PEP		\$3.92	2		□ \$7.7	5		□ \$	6.60			□ \$11.08		□ Decline
Additional Life Ins Maximum of \$500,000. Guarantee issue amount of \$100,000 in increments of \$1,000.	□ 10k	□ 20k	□ 30k	□ 40k	□ 50k	□ 60k	□ 70k	□ 80k	□ 90k	L 100			<u>Other</u>	□ Decline
Spouse Additional Life available in increments of \$5000 guarantee issue amount, \$25,000.		\$10k	2		\$15k			\$20k			\$25k	C.	<u>Other</u>	□ Decline
Dependent Additional Life Ins.(rate is for all children)		[⊐ \$2,	500			□ \$5,000						□ \$10,000	□ Decline
Dependent Basic Life Insurance			⊐\$5,	000			□ Decline							
Short-Term Disability**		I	□ Yes	5			□ No					fer to the formula in your Benefit Enrollment your Disability & Life costs.**		
Long-Term Disability**		[□ Yes	3			D No							

My benefit election is (Check $\sqrt{$ your choice(s)

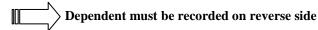
Please provide covered dependent information for any dependent elections above on back of this form.

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 December 2018. 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



Request For Change Section									
ENROLLMENT CHANGE RE	EQUESTED:								
Add DependentDro	p Dependent Add Employee Coverage	Drop Employee Coverage							
Reason for Change (Qualifying Ev	vent):								
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: