WR **WebsterRogers LLP**
CERTIFIED PUBLIC ACCOUNTANTS ♦ CONSULTANTS

GROUP INSURANCE ENROLLMENT/CHANGE FORM 2014 EFFECTIVE DATE:
LOCATION: All

EMPLOYEE INFORMATION:

Name	SSN	
Address		Birthdate
telephone	marital status	hire date

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

Benefit Plan	**Monthly Cost**				
	Single	**Employee/Spouse**	**Emp/Child**	**Family**	**Decline**
Medical- BCBS of SC PPO	☐ $594.59	☐ $1,216.61	☐ $1,106.68	☐ $1,618.65	☐ Decline
Medical- BCBS of SC HDHP (H.S.A)	☐ $516.22	☐ $1,052.53	☐ $957.74	☐ $1,399.16	☐ Decline
Dental- Guardian	☐ $34.81	☐ $66.91	☐ $88.20	☐ $117.02	☐ Decline
Vision- PEP	☐ $7.50	☐ $14.30	☐ $13.10	☐ $23.30	☐ Decline
Additional Life Insurance (Maximum of $150,000)	☐ 10k ☐ 20k ☐ 30k ☐ 40k ☐ 50k ☐ 60k ☐ 70k ☐ 80k ☐ 90k ☐ 100k ☐ 110k ☐ 120k ☐ 130k ☐ 140k ☐ 150k ☐ Decline				
Spouse Additional Life Ins Must have employee Additional life ins. (max. of 2/3employee amount up to $100K)	☐ $10k ☐ $20k ☐ $30k ☐ $40k ☐ $50k ☐ $60k ☐ $70k ☐ $80k ☐ $90k ☐ $100k ☐ Decline				
Dependent Additional Life Ins.(rate is for all children)	☐ $5,000	☐ $10,000	☐ Decline		
Short Term Disability	☐ Accept	☐ Decline			

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 by any PPO. 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 2012. 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_____

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?	If yes, what college?

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

Name	Relationship	Sex	Birth Date	College Student?	If yes, what college?

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

Name	Relationship	Sex	Birth Date	College Student?	If yes, what college?