SC Business Publications

GROUP INSURANCE ENROLLMENT/CHANGE FORM 2016-2017 EFFECTIVE DATE:_____

EMPLOYEE INFORMATION:

Name:			SSN:	
Wage or salary:	Occupation:		Sex:	
Address:	City & State:	Zip Code:	Birth Date:	
Telephone:			Marital Status:	Date of Hire:

Benefit Plan	**Per pay period payroll deduction**				
	Single	**Employee & Spouse**	**Employee & Children**	**Employee & Family**	
BlueChoice PPO Plan	$120.57 □	Please Inquire □	Please Inquire □	Please Inquire □	Decline □
BlueChoice HDHP	$62.38 □	Please Inquire □	Please Inquire □	Please Inquire □	Decline □
Delta Dental Plan	$7.53 □	$27.67 □	$28.88 □	$51.99 □	Decline □
PEP Vision Plan	$4.05 □	$4.05 □	$7.30 □	$11.15 □	Decline □
Disability Insurance	STD □	LTD 1 □	LTD 2 □		

Primary Emergency Contact:

LIFE INSURANCE BENEFICIARY

Name:	Relationship:	SSN:
Same Address as Employee?	If no, address:	

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 LTD INSURANCE 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 SC Business Publications does not recommend, endorse or guarantee the quality of care or service that is provided by any insurance company. 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 next will be held in March 2017 and some plans may require evidence of insurability. I hereby authorize SC Business Publications to deduct from my pay the amount determined. To apply towards the monthly premium for my choice of coverages elected above. I hereby certify the above information is correct. I agree to participate in the SC Business Publications Cafeteria Plan. This will cover medical, dental, and vision plans. My signature for the cafeteria plan will carry over into subsequent years unless I opt out of the cafeteria plan at open enrollment or during a qualifying event.

_____ _____

EMPLOYEE SIGNATURE DATE SIGNED

COVERAGES ACCEPTING_____

REFUSAL OF MEDICAL AND/OR DENTAL INSURANCE AND/OR LIFE INSURANCE COVERAGE:

I am familiar with the group insurance benefits available to me. I understand that to participate, it is necessary for me to authorize deductions from my pay. I DO NOT GRANT SUCH AUTHORIZATION.

_____ _____

EMPLOYEE SIGNATURE DATE SIGNED

COVERAGES REFUSING_____

Medical Covered Dependents

Name	Relationship	Sex	Birth Date	Social Security #

Dental Covered Dependents

Name	Relationship	Sex	Birth Date	Social Security #

Vision Covered Dependents

Name	Relationship	Sex	Birth Date	Social Security #

Request For Change Section

ENROLLMENT CHANGE REQUESTED:

_____Add Dependent _____Drop Dependent

Reason for Change:

_____ Marriage _____ Birth/Adoption _____Termination

_____ Divorce _____ Death _____ Physician Change

_____ Cobra Applicant _____ Address Change _____ Other

- List all family members to be enrolled/dropped from coverage. Do not use nicknames.
- Student verification is required to add children who are older than the eligible age of dependent children.
- Social Security number required for spouse.