GROUP INSURANCE ENROLLMENT/CHANGE FORM 2016/2017
Salaried Employees

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

Name:		SSN:
Address:		
Telephone:	Marital status:	DOB:
Salary:	Date of Hire:	

Benefit Plan	Semi-Monthly Deductions				
	Single	Employee/Spouse	Emp/Child(ren)	Family	Decline
Medical-PPO Plan (BlueChoice)	☐ $85.43	☐ $213.49	☐ $179.33	☐ $256.16	☐ Decline
Medical-HDHP (BlueChoice)	☐ $80.29	☐ $200.66	☐ $168.56	☐ $240.79	☐ Decline

****You may not participate in a Health Savings Account if you elect to enroll in the Traditional PPO Plan. You must be enrolled in the HDHP in order to do so.****

Benefit Plan	Semi-Monthly Deductions			
	Single	Employee+1	Family	Decline
Dental-Delta	☐ $0.00	☐ $0.00	☐ $0.00	☐ Decline

Benefit Plan	Semi-Monthly Deductions				
	Single	Employee/Spouse	Emp/Child(ren)	Family	Decline
Vision- PEP	☐ $3.85	☐ $7.40	☐ $7.70	☐ $11.80	☐ Decline

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

Health Savings Account Elections	
I wish to participate in this account for 2016/2017 ☐	
Medical/Dental/Vision Spending Election (maximum election $3,350 for single coverage and $6,750 for family)	Annual Election: $

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:________________________

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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 Wyman Gordon 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 June 2017. I hereby authorize Wyman Gordon 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. I agree to participate in the Wyman Gordon premium only plan. This will cover my medical, dental, and vision plan.

____ ________________________

EMPLOYEE SIGNATURE DATE SIGNED

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	SSN #

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

Name	Relationship	Sex	Birth Date	SSN #

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

Name	Relationship	Sex	Birth Date	SSN #