South Carolina Bankers Employee Benefit Trust **Benefits Election Form** **For Paper Enrollments Only**
Enterprise Bank

1. Reason for Election:

❑New Election ❑Annual Enrollment Change/Reason: _____ Date of Hire: _____ Effective date:_____

2. Employee Data:

_____ _____ _____ _____ _____
Social Security Number Employee Number Last Name First Name MI

_____ _____ _____ _____
Mailing Address City State Zip

(_____)_____ (_____)_____ _____ Sex: ❑ Male Marital Status: ❑ Single
Home Phone Number Work Phone Number Date of Birth ❑ Female ❑ Married

3. Benefits: Please Print Clearly

Medical	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Children	❑ Employee + Family	❑ No Coverage
Dental	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Children	❑ Employee + Family	❑ No Coverage
Vision	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Children	❑ Employee + Family	❑ No Coverage

Basic Dep Term Life	❑ Dependents Only
Voluntary Employee Term Life	$_____($10K increments up to $500K not to exceed 5x annual Salary, GI max $150K)
Voluntary Spouse Term Life	$_____($5K increments up to $500K not to exceed 100% of Employee amount, GI max $50K)
Voluntary Child Term Life	❑ $10K
Voluntary Short Term Disability	Employee Only

YOU MUST COMPLETE THIS SECTION IN ITS ENTIRETY FOR ANY FAMILY MEMBERS TO BE COVERED OR AFFECTED BY THIS CHANGE:

	Name	Sex	Birth Date	Social Security Number	Medicare	Medicare Claim Number	Medical	Dental	Vision	Dep Life	Vol Life
Employee	****Same as above****	****	****	*******			******	******	******	******	******
Spouse											
Child											
Child											
Child											

4. Beneficiary: Please Print Clearly

	Name	Relationship	DOB or Trust	SSN or Tax ID	Address of Other Instructions
Primary					
Contingent					

5. Enrollment, Section 125/Cafeteria Plan Enrollment, Release of Information Authorization, and HIPPA Special Enrollment

Please enroll me for the Benefit Options indicated on this form. I understand the benefits and limitations by the various plans/coverages and I authorize my employer to make the necessary adjustments in my pay, based on the choices I have made and the deduction amounts provided to me, receipt of which is hereby acknowledged. I am an eligible Colleague working the required hours per week for my employer. I understand that according to federal law, I cannot change my Section 125/Cafeteria benefit plan choices during the plan year unless that change or revocation is on account of consistent with a Special Enrollment or a change in status.

I hereby authorize any licensed physician, dentist, medical practitioner, hospital, clinic or other medically related facility, Insurance company or other organization, institution or person that has any records or knowledge of me or my health, or that of my dependents, to give any provider of benefits elected above such information necessary for processing of claims under the elected plan. I further authorize any provider of benefits elected above to release to my employer, any health care provider, insurance company, and any other person or organization, any such information as it deems necessary for purposes of its provision of benefits under my employer's benefit plan.

IMPORTANT HIPPA NOTICE: If you decline enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if that coverage is lost, provided that after the other coverage ends you request enrollment within 60dyas for Medicaid or a state children's health program or within 30 days for all other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth adoption or placement for adoption. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

I understand that my employer reserves the right to adjust my premiums as a result of plan changes, or changes in my employment such as classification, annual pay, or location. I certify that all information provided is complete and accurate to the best of my knowledge.

Employee Signature: X_____ Date: _____/_____/_____