GROUP BENEFITS ENROLLMENT FORM

FOR COMPANY USE ONLY		
Class: _____	***Per Pay Period Employee Pre-Tax Deductions:***	***Per Pay Period Employee Post-Tax Deductions:***
Salary: _____	Medical: $ _____	Optional Life: $ _____
Department: _____	Dental: $	Dependent Life: $ _____
Occupation: _____	Vision: $	Voluntary STD: $ _____
New Hire Date: _____	401k: $	LTD: Employer Paid
Effective Date: _____	Total: $	Total: $ _____

ENROLLMENT INFORMATION

REASON FOR ENROLLMENT: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event

COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life ☐ STD

STATUS CHANGE: ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination
☐ Electing COBRA (Reason for Election) _____
☐ Waiver of Coverage ☐ PCP Selection/Change ☐ Other _____

PERSONAL INFORMATION

Employee's Full Name		**SSN**		**Occupation**	
Home Address		**City**	**State**	**Zip Code**	**County**
Home Phone	**Work Phone**	**Email Address**		**Date of Birth**	**Date of Hire**
Gender ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married	**Primary Language** ☐ English ☐ Spanish ☐ Other _____	**Hours Worked Per Week**	**PCP Name (if applicable)**	**PCP No.**

DEPENDENTS TO BE COVERED

Name of Person to be Covered Last First MI	**SS #**	**Gender**	**Date of Birth**	**PCP Name** (if applicable)	**PCP No.**	**Existing Patient**
Spouse		☐ M ☐ F				☐ Yes ☐ No
Child * Resides with Employee n Yes n No		☐ M ☐ F				☐ Yes ☐ No
Child * Resides with Employee n Yes n No		☐ M ☐ F				☐ Yes ☐ No
Child * Resides with Employee n Yes n No		☐ M ☐ F				☐ Yes ☐ No
Child * Resides with Employee n Yes n No		☐ M ☐ F				☐ Yes ☐ No
Child * Resides with Employee n Yes n No		☐ M ☐ F				☐ Yes ☐ No

OTHER HEALTH INSURANCE INFORMATION

Are you presently covered on a health insurance plan? ☐ Yes ☐ No **If yes,** how long has this coverage been continuous? _____

If yes, what type of coverage: ☐ Spouse's Coverage ☐ COBRA ☐ Present Employer's Coverage ☐ Medicare/Medicaid ☐ Other _____

Name of Present Insurance Company: _____ Name of Policy Holder: _____

Policy # or Medicare #: _____ Address of Insurance Company: _____

After coverage becomes effective with (Employer) are you or any family members to be covered by another medical insurance or Medicare?

☐ Yes ☐ No

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MEDICAL PLAN (Choose One) - Rates are based on 24 pay period deductions		
☐ Waive Coverage	☐ HDHP	☐ PPO
☐ Employee Only	$0.00 *	$0.00
☐ Employee & Spouse	$130.03	$199.06
☐ Employee & Child(ren)	$91.02	$139.35
☐ Employee & Family	$243.91	$373.41

* We will contribute $50.00 monthly to your HSA account. Please be sure to complete the HSA bank account forms.

DENTAL PLAN - Rates are based on 24 pay period deductions	
☐ Waive Coverage	
☐ Employee Only	$14.19
☐ Employee & Spouse	$29.46
☐ Employee & Child(ren)	$37.09
☐ Employee & Family	$58.08

VOLUNTARY VISION PLAN - Rates are based on 24 pay period deductions	
☐ Waive Coverage	
☐ Employee Only	$4.82
☐ Employee + One dependent	$7.71
☐ Employee + Children	$7.87
☐ Employee + Family	$12.69

VOLUNTARY STD PLAN – Rates are based on employee's age
☐ Elect Coverage
☐ Decline Coverage

COMPANY-PROVIDED INSURANCE

Demo Co provides Basic Life & AD & D insurance coverage of $50,000 and long-term disability coverage.

OPTIONAL TERM LIFE INSURANCE

Optional Term Life (Please indicate your coverage selection)

EMPLOYEE

☐ **Coverage amount chosen:** $ _____
(Please Note: Optional life coverage is available in increments of $10,000, up to a maximum of $100,000, not to exceed 5 times annual earnings. Coverage amounts exceeding $50,000 require evidence of good health satisfactory to Jefferson Pilot.)

☐ **No coverage chosen**

SPOUSE

☐ **Coverage amount chosen:** $ _____
(Available at 50% of employee's total life coverage in increments of $5,000, up to a maximum of $50,000. Coverage amounts exceeding $30,000 require evidence of good health satisfactory to Jefferson Pilot.)

☐ **No coverage chosen**

CHILDREN

☐ **Coverage amount chosen: $10,000**
☐ **No coverage chosen**

PLEASE NOTE: In order to elect spouse and/or child optional life coverage you must elect optional life coverage for yourself.

INSURANCE BENEFICIARY DESIGNATION (Please complete even if Medical and Dental are waived)

Primary Beneficiary Name	**Relationship**	**Social Security Number**	**% of Assets**	**Beneficiary Address** (if different from yours)
Contingent Beneficiary Name	**Relationship**	**Social Security Number**	**% of Assets**	**Beneficiary Address** (if different from yours)

IMPORTANT

I understand and have verified the benefit selections I have made and authorize any payroll deductions required for these selections. I also understand that the above selections for medical, dental, and vision (which are all pre-tax deductions) may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I understand that, by participating in any pre-tax plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. I also have read and understand the enrollment provisions, including restrictions stated on this form.

Printed Name:_____ SSN: _____

Signature:_____ Date: _____

Work Phone No. ( ) _____