FOR COMPANY USE ONLY - REQUIRED			
Date of Hire	***Effective Date***	***Occupation***	***Salary***

ENROLLMENT INFORMATION

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

COVERAGE SELECTED: ☐ Medical

STATUS CHANGE: ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination ☐ COBRA (Reason for Election) _____

PERSONAL INFORMATION

Employee's Full Name (FIRST MI LAST)	**Date of Birth**	**SS#**	**Hours Worked Per Week**

Home Address	**City**	**State**	**Zip**	**County**

Home Phone	**Work Phone**	**Email Address**

Gender	**Marital Status**	**Primary Language**
☐ Male ☐ Female	☐ Single ☐ Married	☐ English ☐ Spanish ☐ Other _____

DEPENDENTS TO BE COVERED

Name of Person to be Covered **Last First MI**	**SS #**	**Gender**	**Date of Birth**	**Address** (if different than employee)
Spouse		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		

OTHER HEALTH INSURANCE INFORMATION

Are you presently covered on a health insurance plan? ☐ Yes ☐ No **If yes,** provide *start* _____ and *end* _____ date of previous coverage?

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

MEDICAL PLAN - WEEKLY COST			
Plan *(Choose One)*	☐ **PPO 1000 80/60**	☐ **EPO 2000 100%**	☐ **EPO 3000 100%**
☐ Waive Coverage	NA	NA	NA
☐ Employee Only	$86.40	$74.95	$65.07
☐ Employee & Spouse	$321.15	$291.44	$265.80
☐ Employee & Child(ren)	$242.19	$218.62	$198.28
☐ Employee & Family	$467.05	$426.00	$390.55

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.

Details of each plan are contained in various insurance contracts and other legal documents. In the event of a conflict the contracts and plan documents prevail.

Compliance information located on www.insuranceisboring.com. See HR for user name and password.

PRINTED COPY - Print Name: _____ Signature _____ Date _____

EMPLOYEE: Please return this form to your manager | **EMPLOYER: Please remit a copy to George Knox's office**