

ENROLLMENT FORM



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A. REQUIRED EMPLOYEE INFORMATION Complete the Enrollment Form and return to your Human Resources Department.

Name:		Phone:	
Social Security #:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			Apt. #:
City:	State:	Zip:	
Hire Date:		Employee ID:	

B. MEDICAL BENEFIT PLAN SELECTION Payroll Deducted Rates - Please select the tier for each product in which you wish to enroll.

<input type="checkbox"/> MEC PLAN	COST	<input type="checkbox"/> PRO PLAN	COST
<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee Only	
<input type="checkbox"/> Employee + Child(ren)		<input type="checkbox"/> Employee + Child(ren)	
<input type="checkbox"/> Employee + Spouse		<input type="checkbox"/> Employee + Spouse	
<input type="checkbox"/> Employee + Family		<input type="checkbox"/> Employee + Family	

C. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Any changes made to the Enrollment Form will require the changes to be dated and initialed by employee.

ACKNOWLEDGEMENT & WAIVER FORM



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D. REQUIRED SIGNATURE You MUST sign and date to be enrolled in coverage

Election of Coverage: I have read and understand the coverage options I have elected. I understand completion of this enrollment form in no way implies I will be accepted for coverage. I understand coverage will take effect only if this enrollment form is approved by the plan sponsor and the plan has been properly funded, provided I meet any eligibility or coverage effective date requirements listed in the plan documents.

Accept coverage options as selected

Date:

Signature:

E. REQUIRED SIGNATURE You MUST sign and date if you wish to decline coverage.

Waiver of Coverage: I, the undersigned employee, understand and acknowledge that: I have been offered an opportunity by my Employer to enroll in affordable employer-sponsored health coverage that meets the minimum value standard set forth in the Patient Protection and Affordable Care Act (ACA) for the applicable period:

- I will not qualify for government credits and subsidies to purchase individual health insurance on a state or federal marketplace or exchange
- I may not cover dependents under the Employer's plan, and
- I may not be able to enroll in the Employer's plan until the next open enrollment, except in a qualified change in status or other limited circumstances.

Decline all coverage options

Date:

Signature: