

## Benefit Enrollment / Change Form

<b>Employee</b>	<b>First Name:</b>	<b>M.I.</b>	<b>Last Name:</b>		<b>SSN:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		
	<b>Mailing/Street Address:</b>	<b>Apt./Ste.</b>	<b>City:</b>		<b>State:</b>	<b>Zip Code:</b>		
	<b>Birth Date:</b>	<b>Hire Date:</b>	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<b>Phone Number:</b>	<b>Email:</b>		
<b>Enrollment</b>	<b>Enrollment Type:</b>	<input type="checkbox"/> New Hire		<input type="checkbox"/> Open Enrollment		<input type="checkbox"/> Qualifying Event		
	<b>Qualifying Event Type:</b>	<input type="checkbox"/> Marriage / Divorce			<input type="checkbox"/> Birth / Death		<input type="checkbox"/> Decline ( <i>See Decline Section</i> )	
		<input type="checkbox"/> Loss of Coverage			<input type="checkbox"/> Reduction in Hours		<input type="checkbox"/> Court Order	
		<input type="checkbox"/> COBRA			<input type="checkbox"/> Other _____		<input type="checkbox"/> Change Name / Address	
<b>Medical</b>	<b>Medical Plan Election:</b>	<input type="checkbox"/> Minimum Essential Coverage (MEC) Plan			<input type="checkbox"/> Decline ( <i>Complete Decline Section</i> )			
	<b>Medical Plan Coverage:</b>	<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee + Child(ren)		<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Family	
<b>Dependents</b>	<b>Name</b>	<b>SSN</b>	<b>DOB</b>	<b>Relationship</b>	<b>Sex (M/F)</b>	<b>Disabled (Y/N)</b>	<b>Include on Medical Plan</b>	
<b>Decline</b>	<input type="checkbox"/> I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.							
<b>Other Insurance</b>	<input type="checkbox"/> I do not have other insurance coverage			<input type="checkbox"/> I have enrolled thru the state or federal Marketplace				
	<input type="checkbox"/> I have other insurance coverage			<input type="checkbox"/> I have other insurance coverage, but intend to cancel that coverage				
	<b>Policy Holder Name:</b>				<b>Policy Holder Date of Birth:</b>			
	<b>Insurance Company Name:</b>				<b>Insurance Company Address:</b>			
	<b>Policy Number:</b>				<b>Group Number:</b>			
<b>Names of Covered Individuals:</b>								
<b>Employee Authorization</b>	<input type="checkbox"/> I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.							
	<input type="checkbox"/> To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.							

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Employee Signature

\_\_\_\_\_  
Date