



Benefit Enrollment / Change Form

Company Name: _____

Employee	First Name:	M.I.	Last Name:		SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Mailing/Street Address:	Apt./Ste.	City:		State:	Zip Code:
	Birth Date:	Hire Date:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Phone Number:	Email:
Enrollment	Enrollment Type:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Qualifying Event	<input type="checkbox"/> Decline (<i>See Decline Section</i>)	
	Qualifying Event Type: (<i>If applicable</i>)	<input type="checkbox"/> Marriage / Divorce		<input type="checkbox"/> Birth / Death		<input type="checkbox"/> Court Order
		<input type="checkbox"/> Loss of Coverage		<input type="checkbox"/> Reduction in Hours		<input type="checkbox"/> Change Name / Address
		<input type="checkbox"/> COBRA		<input type="checkbox"/> Other: _____		
Medical	Medical Plan Election:	<input type="checkbox"/> Enhanced MEC <input type="checkbox"/> Premier MEC		<input type="checkbox"/> Decline (<i>Complete Decline Section</i>)		
	Medical Plan Coverage:	<input type="checkbox"/> Employee Only			<input type="checkbox"/> Employee + Child(ren)	
Dependents	Name	SSN	Relationship	Sex (M/F)	Disabled (Y/N)	Include on Medical Plan
Decline	<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.					
	<input type="checkbox"/> I understand by not enrolling in this plan or a Marketplace health plan as mandated by PPACA, that I may be subject to a tax penalty.					
Other Insurance	<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			
	Policy Holder Name:			Policy Holder Date of Birth:		
	Insurance Company Name:			Insurance Company Address:		
	Policy Number:			Group Number:		
Names of Covered Individuals:						
Employee Authorization	<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.					

Employee Signature _____

Date _____