2020 EMPLOYEE HEALTH ENROLLMENT FORM

PLEASE PRINT OR TYPE ALL INFORMATION

Chugach

Revised 10/2019

Reason for Action:

New Enrollment ☐ Change in Dependent Coverage ☐

Change in Status (FT/PT/OC) ☐ Annual Enrollment ☐

Employer:	Company and Site Location:	Position/Job Title:
Last Name:	First Name:	Middle Initial:
Address:	City:	State: Zip:

Home Phone:	Date of Hire:	Date of Birth:	Social Security #:	Gender: M☐ F☐	Marital Status:

HEALTH INSURANCE BENEFITS

FEHB – MEDICAL/Rx PLAN (Attach completed FEHB form)

☐ I elect new coverage, or change to existing election, under the FEHB Plan name or code: _____

☐ No change to existing election

☐ I elect no coverage. **SEMI-MONTHLY COST** **$**_____

MERITAIN – DENTAL/VISION PLAN

Indicate your new coverage election, or change to existing election, and write the corresponding amount on the semi-monthly cost line.

☐ Employee Only	$ 9.20	☐ No change to existing election
☐ Employee + Spouse	$19.85	☐ I elect no coverage.
☐ Employee + Domestic Partner*	$19.85	
☐ Employee + Child(ren)	$21.09	**SEMI-MONTHLY COST** **$**_____
☐ Employee + Family	$32.22	

Meritain Dependent Information I wish to enroll my dependent(s) Yes ☐ No ☐

Please list name(s) of family members to be insured under this plan.	Sex	Date of Birth	Employer
Spouse or Domestic Partner* SS #	M / F		
Child	M / F		SS #
Child	M / F		SS #
Child	M / F		SS #
Child	M / F		SS #

*Completed Domestic Partner Affidavit and Declaration of Tax Status Form must accompany the enrollment form.

Are you, or any of the dependents you wish to enroll, covered under any other health, dental, or vision plan? ☐ Yes ☐ No

Indicate who has other coverage ☐ You ☐ Your Spouse ☐ Your Domestic Partner ☐ Your Dependent Child(ren)

Name of other insurance company _____ Group ID: _____

Address _____

List those who are covered _____

I understand that the pre-tax eligibility of any plan requires that I pre-elect coverage choices for the calendar year and that I may not change such choices absent a family status change. I hereby certify that all information on this enrollment form is true and complete; and that I am an eligible employee of the Participating Employer named above, and that I am actively at work on this date. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF MEDICAL INFORMATION, OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND OR MY DEPENDENT(S). I understand that the coverage applied for will not become effective unless and until the first premium has been paid and the Company unconditionally approves and accepts the application. I authorize deductions, if any, from any earnings toward the cost of the coverage. I authorize my employer to reduce my salary as needed to pay for the benefit choices I have made above. I also understand that if I do not elect coverage at this time for myself or my dependents, that evidence of insurability must be furnished as a condition of enrollment at a later date.

DATE OF SIGNATURE

_____

Month / Day / Year

X_____

Signature of Employee

INSURANCE EFFECTIVE DATE

January 1, 2020

Month / Day / Year