2024 EMPLOYEE HEALTH ENROLLMENT FORM (Medical/Rx/Dental/Vision)

PLEASE PRINT OR TYPE ALL INFORMATION

Reason for Action:

New Enrollment ☐ Change in Dependent Coverage ☐

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

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

Phone:	Date of Hire:	Date of Birth:	Social Security #:	Gender:	Marital Status:

Federal Employees Health Benefits (FEHB) – MEDICAL/Rx PLAN (Attach completed SF2809 FEHB form)

☐ I elect coverage under the FEHB
☐ No change to my existing FEHB election
☐ I am changing my current plan
☐ I waive medical benefits/coverage

Plan name and 3 digit code:_____

Semi-monthly cost $_____

MetLife Dental/VSP Choice Vision Plan

Mark your existing or new coverage election and write the corresponding amount on the semi-monthly cost line.

☐ Employee Only	$ 7.21
☐ Employee + Spouse	$15.29
☐ Employee + Domestic Partner*	$15.29
☐ Employee + Child(ren)	$15.49
☐ Employee + Family	$24.02

☐ No change to existing election
☐ I waive dental and vision benefits/coverage

Semi-monthly cost $_____

MetLife/VSP Dependent Information I am enrolling my dependent(s) Yes ☐ No ☐

Please list name(s) of family members to be insured under this plan. (Dependent verification documents required)	Gender	Date of Birth	Social Security Number
Spouse or Domestic Partner			
Child			
Child			
Child			
Child			

*Completed Domestic Partner Affidavit and Declaration of Tax Status Form must accompany the enrollment form. Domestic Partner premiums are withheld post-tax.

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 MISSTATEMENT OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND OR MY DEPENDENT(S).

I authorize my employer to reduce my salary as needed to pay for the benefit choices I have made above. I understand that the coverage applied for will not become effective unless and until the first premium has been paid and the Company approves and accepts the application. I understand that the pre-tax elections of any plan coverage I select are for the calendar year and that I may not change such choices absent a qualifying life event. 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.

DATE OF SIGNATURE

_____ _____

Month / Day / Year **Signature of Employee**