

2021 EMPLOYEE HEALTH ENROLLMENT FORM

PLEASE PRINT OR TYPE ALL INFORMATION

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 <input type="checkbox"/> F <input type="checkbox"/>	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

INSURANCE EFFECTIVE DATE

Month / Day / Year

X

Signature of Employee

Month / Day / Year