

2019-20 MEDICAL/DENTAL/VISION ENROLLMENT / CHANGE FORM



HR USE ONLY
Effective Date of Insurance Change: Reason for Change: _____ _____
Change from: _____ Change to: _____

Name: (Last, First, Middle)		Date of Hire:	
Street or PO Box:		City:	State: Zip Code:
Telephone:	SS #:	Race:	Gender:

MEDICAL:

HSA

- Employee Only
- Employee + 1 Child
- Employee + Children

- Decline Coverage

PPO

- Employee Only
- Employee + 1 Child
- Employee + Children

- Decline Coverage

Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you and/or any covered dependents have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

DENTAL:

- Employee Only
- Employee + Spouse
- Employee + 1 Child
- Employee + Children
- Employee + Family
- Decline Coverage

Disclaimer: It is the coworker's responsibility to update his/her dependents on all benefit selections. Example: A beneficiary change in BCBS does not update life, retirement or 401K beneficiaries. Each vendor must be updated if a change occurs.

VISION:

- Employee Only
- Employee + Spouse
- Employee + Children
- Employee + Family
- Decline Coverage

DEPENDENTS COVERED:

Add	Delete	Last Name	First Name	MI	Gender	SS #	DOB	Relationship	Type of Coverage
Add	Delete								Medical Dental Vision
Add	Delete								Medical Dental Vision
Add	Delete								Medical Dental Vision
Add	Delete								Medical Dental Vision

I understand this is a legal binding document and I hereby authorized deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will remain in effect until revoked in writing. Medical, dental, and vision insurance are paid on a pre-tax basis unless a waiver is submitted. Social Security numbers for any spouse or child covered on a benefit plan **ARE REQUIRED** in order to comply with ACA reporting requirements.

Employee Signature

Date