

**EMPLOYEE ELECTION FORM (THIS IS NOT AN APPLICATION FOR INSURANCE)**

New Enrollee  Coverage Change  Add/Delete Dependents  Termination  COBRA  Direct Bill COBRA  Waiver (Complete 1,3,5 & 6 Only)

Employer: \_\_\_\_\_ Customer #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Requested Effective Date \_\_\_\_\_

<b>1</b>	Employee Name _____ Last First M.I.		Social Security # _____																																																																															
	Address _____		Sex _____ Birth Date _____																																																																															
	City _____ ST _____ Zip _____		M/F Home Phone _____																																																																															
	Full-Time Hire Date _____ Hours worked/wk _____		Marital Status S/M/D/W _____																																																																															
	Are you actively at work on a full-time basis for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Marital Change _____																																																																																	
<b>2</b>	<b>TO BE COMPLETED ONLY IF APPLYING FOR LIFE/AD&amp;D, STD OR LTD COVERAGE</b>																																																																																	
	Occupation _____		Class _____ Annual Salary _____																																																																															
	Beneficiary _____		Relationship _____																																																																															
<b>3</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 15%;">Last</th> <th style="width: 15%;">First</th> <th style="width: 15%;">M.I.</th> <th style="width: 10%;">Soc. Sec. No.</th> <th style="width: 10%;">Birth Date</th> <th style="width: 5%;">M/F</th> <th style="width: 20%;">Primary Care Physician or Med. Center Name</th> <th style="width: 10%;">PCP or MC ID #</th> <th style="width: 5%;">Existing Patient (Y/N)</th> <th style="width: 5%;">Disabled (Y/N)</th> <th style="width: 5%;">Student (Y/N)</th> </tr> </thead> <tbody> <tr><td>Emp</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Sp</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Ch</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Ch</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Ch</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>											Last	First	M.I.	Soc. Sec. No.	Birth Date	M/F	Primary Care Physician or Med. Center Name	PCP or MC ID #	Existing Patient (Y/N)	Disabled (Y/N)	Student (Y/N)	Emp												Sp												Ch												Ch												Ch											
	Last	First	M.I.	Soc. Sec. No.	Birth Date	M/F	Primary Care Physician or Med. Center Name	PCP or MC ID #	Existing Patient (Y/N)	Disabled (Y/N)	Student (Y/N)																																																																							
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	PARTICIPATING DENTIST/PROVIDER CODE (if required): NAME/CODE: _____																																																																																	
<b>4</b>	<b>Medicare:</b> Y _____ N _____ Date (Part A) ____/____/____ Date (Part B) ____/____/____ Medicare # _____ <b>TEFRA:</b> Check here if all of the following apply to you. 1) Age 65 or over. 2) Eligible for Medicare. 3) Actively employed. 4) Continuing group coverage as primary coverage. 5) Your employer meets TEFRA requirements. Self _____ Spouse _____																																																																																	
<b>5</b>	<b>BENEFIT ELECTIONS:</b>																																																																																	
	<b>Medical Plan (Gp# _____)</b> Carrier: _____ Plan: _____			<b>Dental Plan (Gp# _____)</b> Carrier: _____ Plan: _____			<b>Vision Plan (Gp# _____)</b> Carrier: _____ Plan: _____			<input type="checkbox"/> <b>Life/AD&amp;D</b> <input type="checkbox"/> Dep. Life <input type="checkbox"/> None Have you used tobacco products within last 2 Yrs? <input type="checkbox"/> Y <input type="checkbox"/> N Carrier: _____ (Gp# _____) Benefit \$ _____ Sup. \$ _____																																																																								
	<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child <input type="checkbox"/> Individual/children <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Over 65 & Working <input type="checkbox"/> Over 65 & Retired <input type="checkbox"/> Waive Coverage			<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child <input type="checkbox"/> Individual/children <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage			<input type="checkbox"/> Individual <input type="checkbox"/> Individual/child <input type="checkbox"/> Individual/children <input type="checkbox"/> Individual/adult <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage			<input type="checkbox"/> <b>STD</b> <input type="checkbox"/> Vol. STD <input type="checkbox"/> None Carrier: _____ (Gp# _____) Benefit/week \$ _____																																																																								
										<input type="checkbox"/> <b>LTD</b> <input type="checkbox"/> Vol. STD <input type="checkbox"/> None Carrier: _____ (Gp# _____) Benefit/ month \$ _____																																																																								
<b>6</b>	<b>OTHER INSURANCE INFORMATION (Must Complete)</b>																																																																																	
	Did you or your dependents have prior coverage with another insurer? <input type="checkbox"/> Yes/ Group coverage <input type="checkbox"/> Yes/Non-Group coverage <input type="checkbox"/> No																																																																																	
	Other Health Insurer Name/Policy # _____					Insurer/Carrier Address _____																																																																												
	Will you or your dependents described on this form continue with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																	
	Who is covered? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> All				Effective Date: _____				Term Date: _____																																																																									

CERTIFICATION: I hereby elect, on behalf of myself and each listed dependent for the coverage(s) indicated. If accepted, coverage(s) will be provided according to the terms and conditions of the benefit plan(s) between my employer or (if Applicable) myself and I agree to be bound by the plans of which this form will become part. I also agree to pay current and future subscription charges for the coverage(s) provided if required by my employer. I have carefully read this Election Form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date.

EMPLOYEE SIGNATURE: ✓ \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYER SIGNATURE/VERIFICATION: ✓ \_\_\_\_\_ DATE: \_\_\_\_\_

**IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS EMPLOYEE ELECTION FORM.**