



Enhanced MEC Plan



Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information

First Name		Last Name		Social Security Number	
Address			City	State	Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Date of Birth		Date of Hire
Phone Number:			Email Address:		

Please Circle Desired Coverage:

Employee Only \$27.00/Week	Employee + Spouse \$41.00/Week	Employee + Child(ren) \$39.00/Week	Family \$66.00/Week
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Dependent

First Name		M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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Dependent

First Name		M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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Dependent

First Name		M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature _____ Date _____

EMPLOYEES DECLINING I am DECLINING coverage

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING - YOU MUST SIGN HERE

Employee Signature _____ Date _____