**Benefit Election and Authorization Form**

Please complete all information in this section:

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  | SSN:  | Gender:  |  |
|  |  |  |  |  |  |
| Address:  | City:  | State: | Zip: |
|  |  |  |  |  |  |
| Phone:  | Date of Birth:  |  |  |

**If you wish to make changes to any of your plan choices, or to persons covered, please contact your Human Resources representative. All forms must be turned in to Human Resources to ensure proper coverage status.**

##### HEALTH INSURANCE ELECTION

Check the boxes below to indicate the plan in which you are enrolling. Rates listed below are the employee’s weekly cost of insurance.

|  |  |
| --- | --- |
| **Type of Coverage** | **Blue Cross Blue Shield** |
| **Single** | [ ]  $ |
| **Two Person** | [ ]  $ |
| **Family** | [ ]  $ |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Spouse: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |

Does anyone listed above have other health care coverage?

If so, please complete the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Self |  | Spouse |  | Dependent |
|  |
| Type of Coverage |
|  |  |  |  |  |  |
|  | BCBS |  |  |  |  |
|  | OTHER | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  |  |  |  |  |  |
|  | MEDICARE No.: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| Effective Date for PART A: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Effective Date for PART B: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

##### DENTAL INSURANCE ELECTION

Check the boxes below to indicate the plan in which you are enrolling. Rates listed below are

the employee’s weekly cost of insurance.

|  |  |
| --- | --- |
| **Type of Coverage** | **Guardian Dental** |
| **Single** | [ ]  $ |
| **Two Person** | [ ]  $ |
| **Family** | [ ]  $ |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Spouse: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |
| Child: |  | SSN: |  | DOB: |  | Gender |  | Rel. Code |  |

##### MEDICAL AND DENTAL INSURANCE WAIVER

I do not wish to participate in the: [ ]  Medical [ ]  Dental benefit program.

I, hereby, acknowledge that I have been offered information to participate in DEM Group, LLC and/or it’s Affliates Medical and Dental Insurance program and have declined to participate in one or both of these plans. I understand that I may not re-enter the plan, except at open enrollment or through loss of other current coverage. I further understand that if I decline the dental coverage indicated above, that I may be subject to benefit limitations if I wish to apply for such coverage in the future.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION

I have read and understand the explanation I have received regarding my options under the Benefit Program.

I authorize the company to redirect my pay on a pre-tax basis for all benefits indicated above. I understand that the benefit options I have chosen will remain in force for the rest of the plan year and may only be changed at open enrollment or if I have a change in family status/life events.

Changes in Family Status/Life Events include:

* My marriage or divorce
* My dependent child marries
* Death of member, spouse or dependent
* Birth or adoption of a dependent
* Dependent child gains or loses full-time student status
* Eligible dependent child age reaches 25 years
* Loss of coverage for myself, spouse or eligible dependent child

I am required to notify Human Resources of Family Status/Life Events that may affect eligibility for health and other related benefits for me or my dependents within 30 days of the event. Failure to properly update my information may result in disciplinary action.

By signing below I attest that the dependents enrolled in the plan are eligible for coverage as defined by the Plan Guidelines.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_