

Enhanced MEC Plan 1

Benefits Enrollment Form  New Employee  Rehire Rehire Date

Employee Information

Name (First and Last) BAPWICH OCHUDHO		Social Security Number 676-77-6778	
Address 1111 7th Ave S Apt 102 Saint Cloud MN 56301-2558		City Saint Cloud	State MN
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth 01/01/1986	Date of Hire 03/06/18
Phone Number: 507-400-5110		Email Address: BapwichOchudho@yahoo.com	

**Please Select Desired Coverage:**

Employee Only - \$24.00/Week     Employee+Spouse - \$38.00/Week     Employee+Child(ren) - \$36.00/Week     Family - \$63.00/Week

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 <input type="checkbox"/> Domestic Partner
------------	------	-----------	-------------------	------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------

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 <input type="checkbox"/> Domestic Partner
------------	------	-----------	-------------------	------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------

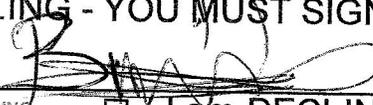
First Name	M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
------------	------	-----------	-------------------	------------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

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 03/07/2018

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 \_\_\_\_\_