

Enhanced MEC Plan Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information			Social Security Number	
Name (First and Last) Kyle Stuart			616-26-6751	
Address 4131 1/2 Vrain St		City Denver	State CO	Zip Code 80212
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth 5/6/89	Date of Hire 8/17/16	
Phone Number: 209-642-3986		Email Address: foxstuart@gmail.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		Social Security #	Birth Date	Sex	Relationship
Marisa	Stuart	612-70-6783	7/25/92	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<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
_____	_____
_____	_____
_____	_____

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: Kyle Stuart Date: 8/29/16

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 _____