

New Employee
 Rehire Rehire Date _____

For Status Change Please Check: You **MUST** provide a supporting Document
 Change of Status Birth/ Spouse Loss of Coverage Plan
 Adoption Change
 Marriage Cancel Employee/Dependents
 Divorce
 Date of Status Change:

Benefits Enrollment Form

Employee Information			
Name (Last, First, MI) Hale Thomas W		Date of Birth 09/03/1994	Social Security Number 210 74 0533
Address 917 Locust Street		City Collegesville	State PA
Zip Code 17426	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Divorced	Phone Number: Date of Hire

Please Select Coverage Elected: Enhanced MEC Plan
Coverage Level :
 Single - \$24.00/Week Employee+Spouse - \$38.00/Week Employee+Child(ren) - \$36.00/Week Family - \$63.00/Week

Email Address:

Dependent Information				
Dependent				
Last Name	First Name	M.I.	Sex	Birth Date
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #			<input type="checkbox"/> Medical	Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate
Dependent				
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #			<input type="checkbox"/> Medical	Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate
Dependent				
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #			<input type="checkbox"/> Medical	Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate

Other coverage information including Medicare/Medicaid
 NAME OF PERSON COVERED (LAST, FIRST, MI):
 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 Declining due to other 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 **Thomas W Hale** Date **06/27/2016**