

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information			
Name (First and Last) Wilfred Nieto		Social Security Number 440662258	
Address 202 East 6th St.		City Grandfield	State Oklahoma
		Zip Code 73546	
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 05/18/1973	Date of Hire 4/10/2017
Phone Number: 5807550525		Email Address: wilnieto@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				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

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

Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<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
	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 Wilfred Nieto Date Apr 25, 2017
Wilfred Nieto (Apr 25, 2017)

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 Apr 25, 2017

