

Late Enrollment (Please see *Benefits Handbook* for rules on late enrollment.)

□ Change: □ Coverage (Complete Parts A,B,C,D,F,G,H,I) □ Add Dependent(s) □ Delete Dependents (Complete Parts A,B,C,D,H,I) □ Health Plan (Complete Parts A,B,D,H,I) □ Life Insurance Beneficiary (Complete Parts A,E,F,I)

## **Benefits Enrollment Form**

		e (Complete Pa	arts A,I)		🗆 Other				
PART A Legal Marital Status: 🗆 Married	□ Not Married	Sex: 🗆 Mal	le 🗆 Fem	le Da	te of Birth:		Employment I	Date:	
LAST	FIRST	-	Μ	F0	RMER LAST NAME (IF C	HANGED)	SOCIAL SECURI	TY NUMBER	
Name:									
STREET OR P. O. BOX	CITY			STATE ZIP C	DDE TELEPHONE		E-MAIL ADDRES	SS	
Address:					( )	)			
PART B MEDICAL INSURANCE COVERAGE	(42-DAY WAITING PERIOD)	🗆 RF PPO Pla	n 🗆 HM	) Name:			(Additional form r	required) 🗆 I Decline	Coverage
Please choose one of the following:	Immediate prior coverage with Blue Cross? 🗆 Yes 🗆 No 🛛 Do you or any of your dependents have any other group health insurance? 🗆 Yes 🗆 No								
Employee Only     Employee & Child(ren)	If yes, please indicate policyholder, insurance company, and identification number:								
Employee & Spouse or Domestic Partner (requires a	additional documentation and appro	oval)							
PART C DENTAL/VISION COVERAGE (6-MONTH WAITING PERIOD) DENTAL MAJOR/PROSTHODONTIC (1-YEAR WAITING PERIOD ) 🛛 Individual 🖓 Family 🖓 I Decline Coverage									
PART D COVERED DEPENDENTS – COMPLETE IN FULL – LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM									
	RST NAME		MI GEN	1	ECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVER	AGE
								☐ Medical ☐ Dental	□ Vision
								☐ Medical  ☐ Dental	□ Vision
								☐ Medical ☐ Dental	□ Vision
								🗆 Medical 🗆 Dental	□ Vision
								🗆 Medical 🛛 Dental	□ Vision
PART E BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (6-MONTH WAITING PERIOD) BENEFICIARY DESIGNATION									
NAME	RELATIONSHIP		ADDRESS					Primary-Class 1 Conting	
									ntingent
									ntingent
								🗆 Primary 🛛 Co	
									ntingent
List additional beneficiaries on back of this form. B					are deceased.				ntingent
List additional beneficiaries on back of this form. B (If a class of beneficiaries contains more than one					are deceased.				ntingent
(If a class of beneficiaries contains more than one	person, the benefit is apport	ioned equally unlo	ess specifie	otherwise.)		Decline Coverage			ntingent
(If a class of beneficiaries contains more than one	person, the benefit is apport DEATH AND DISMEMBERM	ioned equally unle	ess specifie <b>(6-MONTH</b>	otherwise.)	)		□ 4X □ 5X		ntingent
(If a class of beneficiaries contains more than one <b>PART F OPTIONAL LIFE AND ACCIDENTAL</b>	person, the benefit is apport DEATH AND DISMEMBERM or medical statement requi	ioned equally unle IENT INSURANCE ired Multiple o	ess specifie <b>(6-MONTH</b> of earnings, c	l otherwise.) WAITING PERIOD ffset by Basic Life	) 🗌     e amount 🗌 1>	X □ 2X □ 3X			ntingent
(If a class of beneficiaries contains more than one <b>PART F OPTIONAL LIFE AND ACCIDENTAL</b> <b>Employee Paid – Submit within 60 days of hire</b> List additional beneficiaries on back of this form. B	person, the benefit is apport DEATH AND DISMEMBERM or medical statement requi Beneficiaries will be the same	ioned equally unlo IENT INSURANCE ired Multiple o e as for Basic Life	ess specifie E ( <b>6-MONTH</b> of earnings, c e (Part E), un	l otherwise.) WAITING PERIOD ffset by Basic Life ess you list differe	) 🗌     e amount 🗌 1>	X 2X 3X the back of this for	m.		ntingent
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