



## BENEFITS ENROLLMENT / CHANGE FORM

Please **print** when completing this form. This form is used to enroll or make changes in your medical, dental, or vision plans. Remember: Changes can only be made during the open enrollment period or within 30 days of a lifestyle change with proper documentation. Please contact HR if you have questions about what qualifies as a lifestyle change.

◆ Employee Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Check here if this is a **new** address....

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Health Insurance**     HMO     POS     HMO (Alternate 100% Coinsurance)

Employee Only     Employee + Spouse     Employee + Children     Employee + Family

		Spouse/Children				
Add	Delete	Name	SS#	DOB	M/F	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____

### Dental Insurance

Employee Only     Employee + Spouse     Employee + Children     Employee + Family

		Spouse/Children				
Add	Delete	Name	SS#	DOB	M/F	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____

### Vision Insurance – Voluntary Coverage

Employee Only     Employee + Spouse     Employee + Children     Employee + Family

		Spouse/Children				
Add	Delete	Name	SS#	DOB	M/F	
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____

**\*\*Please see HR if you would like to update your Life Insurance beneficiary or Emergency Contact information\*\***

Employee Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

HR use only:    \_\_\_ changed in Munis    \_\_\_ changed with Ins. Co.    \_\_\_ Ceridian (New Hire/Qualifying Event)