



# Benefits

## Enrollment/Change Form

- Newly Eligible Associate
- Mid Plan Year Change - Qualified Change in Family Status Form attached

Effective Date of Coverage: \_\_\_\_\_

Department Number: \_\_\_\_\_

### ASSOCIATE INFORMATION (PLEASE PRINT)

Last Name		First Name		M.I.	Social Security Number	
Home Address			City	State	Zip	Phone Number ( ) -
Email		Hire/Eligible Date / /		Birth date / /		Job Title
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		Marriage Date / /	Spouses Name		Spouses Birthdate / /
Do you or any of your covered dependents have other health insurance coverage?				<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete <b>OTHER INSURANCE</b> Section below.	
Are you, your spouse, or any dependents eligible for Medicare?				<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which persons?	

### MEDICAL-RX/DENTAL/VISION ELECTIONS

#### Wellness Plan

#### Traditional Plan

#### Waive

Medical	Dental	Vision		Add	Delete	Change	Last Name, First Name, MI	Birthdate	Social Security Number	Gender
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Associate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /	- -	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /	- -	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /	- -	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /	- -	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /	- -	M / F

I **DECLINE** the following plan(s) marked \_\_\_ Medical-RX, \_\_\_ Dental, \_\_\_ Vision Insurance through Lourdes. I have other coverage or I have chosen to have no insurance at this time. I understand that my next opportunity to elect coverage for myself or my dependents will be at Open Enrollment, unless I have a qualifying family/work status change.

### OTHER INSURANCE

In order to properly process claims for your covered dependents, we need information in regard to any other health plan under which they may be covered. Please answer the following questions:

Name of Spouse's Employer _____	Are any benefits available from:	Employee	Spouse	Children	Dependents covered _____
Address of Employer _____	A. Any other group health plan?	Yes No	Yes No	Yes No	Name of other insurance company _____
Phone Number of Employer _____	B. Any other dental plan?	Yes No	Yes No	Yes No	Name of Employee _____
If divorced, is there a court order for children's coverage? _____	C. HMO?	Yes No	Yes No	Yes No	Name of other employer _____
If no Court Order, with whom do the children reside _____	D. Prescription drug plan?	Yes No	Yes No	Yes No	Effective Date: _____ Termination Date: _____

### VOLUNTARY LONG-TERM DISABILITY INSURANCE

<input type="checkbox"/> I elect to PURCHASE Voluntary Long-Term Disability Insurance. <input type="checkbox"/> 90 Day Elimination Period <input type="checkbox"/> 70% Up Grade Plan <input type="checkbox"/> 180 Day Elimination Period	<input type="checkbox"/> I <b>DECLINE</b> or cancel the purchase of Voluntary Long-Term Disability Insurance. I understand that future elections may require Evidence of Insurability or contain pre-existing condition exclusions.
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### SUPPLEMENTAL LIFE INSURANCE

<input type="checkbox"/> I elect to PURCHASE Supplemental Life Insurance. <input type="checkbox"/> COMPLETE SEPARATE ENROLLMENT FORM	<input type="checkbox"/> I <b>DECLINE</b> or <b>CANCEL</b> the Supplemental Life Insurance for myself, my spouse, and children. I understand I have been given the option to purchase Supplemental Life Ins. and that future elections may require Evidence of Insurability.
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### AFLAC SUPPLEMENTAL INSURANCE

<input type="checkbox"/> I have decided to meet with the Aflac Supplemental Insurance representative. Please ask the representative to setup a meeting with me. I understand I am eligible for pre-tax benefits on the first of the month following 90 days of employment.	<input type="checkbox"/> I <b>DECLINE</b> Aflac Supplemental Insurance. I understand I have been given the option to purchase Supplemental Insurance.
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### LEGAL PLAN

<input type="checkbox"/> I elect to PURCHASE the Legal Plan. <input type="checkbox"/> Employee Plan <input type="checkbox"/> Family Plan	<input type="checkbox"/> I <b>DECLINE</b> or <b>CANCEL</b> the Legal Plan. I understand I have been given the option to purchase the Legal Plan.
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### YOUR AUTHORIZATION

I hereby make application for the benefit plans for which I am eligible. I certify that the benefits of these plans have been thoroughly explained to me. I authorize payroll deductions of required contributions, if any. I understand that subject to Federal and State income tax laws, the health and dental deductions and contributions to the reimbursement accounts will be made before taxes. I understand that I cannot change the health, dental or vision elections or add or delete dependent health or dental coverage during the plan year unless I have a qualifying change in family status. I also certify that the dependents listed are eligible for dependent Health and Dental coverage.

Associate Signature _____	Date _____
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