HEALTH & DENTAL INSURANCE ENROLLMENT FORM

Personal Information (please print)

Employee Name			Dept. Code
Home address (street)	City	State	Zip Code
Department	Social security number		
Hire date	Date of birth	Sex	Marital status

☐ I authorize my employer to make the following deductions from my payroll. I understand that this election and salary reduction is for the period through the end of the current calendar year and cannot be revoked or changed except as provided by IRS guidelines. Premium deductions for medical and dental will begin the month prior to the effective date.

☐ WAIVER: I decline medical coverage. I understand that if I decide to enroll at a later date due to loss of other coverage, I must request enrollment within 30 days after my coverage ends. In addition, if I have a change in dependents as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

MEDICAL COVERAGE ☐ **pre-tax** ☐ **after-tax**

- ☐ Single $80.00 per month
- ☐ Single + 1 $198.00 per month
- ☐ Family $291.00 per month
- ☐ I do not wish medical coverage

DENTAL COVERAGE ☐ **pre-tax** ☐ **after-tax**

- ☐ Single $12.00 per month
- ☐ Single + 1 $34.00 per month
- ☐ Family $46.00 per month
- ☐ I do not wish dental coverage

Signature | Date

Dependents to be Covered under Medical and/or Dental Insurance

	First name	Middle	Date of Birth			Cover under
Spouse - Last Name						☐ Medical ☐ Dental
Dependent - Last Name	First name	Middle	Date of Birth	Relationship	☐ F ☐ M	Cover under ☐ Medical ☐ Dental
Dependent - Last Name	First name	Middle	Date of Birth	Relationship	☐ F ☐ M	Cover under ☐ Medical ☐ Dental
Dependent - Last Name	First name	Middle	Date of Birth	Relationship	☐ F ☐ M	Cover under ☐ Medical ☐ Dental
Dependent - Last Name	First name	Middle	Date of Birth	Relationship	☐ F ☐ M	Cover under ☐ Medical ☐ Dental

Flexible Spending Accounts

I authorize [redacted] to make the following deductions from my payroll. I understand that this election and salary reduction is for the period through the end of the calendar year and cannot be revoked or changed except as provided by IRS guidelines. I understand I must forfeit any amounts remaining in my Flexible Spending Account(s) after reimbursement for eligible expenses incurred during the plan year, and that funds cannot be transferred from one account to another.

☐ Medical reimbursement (maximum $5,000)	Annual Amount: $
☐ Dependent care reimbursement (maximum $5,000)	Annual Amount: $
Signature	Date