



# MEDICAL PLAN ENROLLMENT FORM

WORKSITE EMPLOYER	SOCIAL SECURITY NUMBER
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## SECTION 1 – EMPLOYEE INFORMATION

EMPLOYEE LAST NAME	FIRST NAME	M.I.	GENDER	DATE OF BIRTH / /
EMPLOYEE MAILING ADDRESS		CITY		STATE ZIP
HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )	ORIGINAL HIRE DATE / /		A-PLUS HIRE DATE / /

## SECTION 2 – SPOUSE INFORMATION

SPOUSE'S LAST NAME	FIRST NAME	M.I.	GENDER	DATE OF BIRTH / /
NAME OF SPOUSE'S EMPLOYER	SPOUSE'S WORK TELEPHONE NUMBER	SOCIAL SECURITY NUMBER		

## SECTION 3 – DEPENDENT CHILDREN INFORMATION

DEPENDENT'S LAST NAME	FIRST NAME	M.I.	RELATION	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
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## SECTION 4 – MEDICAL PLAN COVERAGE ELECTIONS

<b>Check Plan Option Desired</b> <input type="checkbox"/> Essential <input type="checkbox"/> Value <input type="checkbox"/> Select Option <input type="checkbox"/> Preferred Option <input type="checkbox"/> Choice Option	<input type="checkbox"/> Med Save 1 <input type="checkbox"/> Med Save 2	<b>Check Coverage Type Desired</b> <input type="checkbox"/> Single <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + One Child <input type="checkbox"/> Family
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## SECTION 5 – MEDICAL PLAN WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents because of other group health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I choose to waive my right to participate in the A-Plus Benefits Employee Medical Plan and certify that I have other **group** coverage

**Waiver** Name of Health Plan: \_\_\_\_\_

Group or Policy Number: \_\_\_\_\_

Individuals Covered: \_\_\_\_\_

**Not Eligible**  Part-Time (Less than 30 hours per week)  
 Seasonal/Temporary Employee

## SECTION 6 – EMPLOYEE SIGNATURE AND CERTIFICATION OF INFORMATION ACCURACY

I understand the information presented to me about this medical plan and I have made the coverage selections represented on this form. I authorize A-Plus Benefits to make deductions from my earnings for my share of the cost, if any, of the benefits to which I may become entitled. I also understand that coverage may only be dropped on January 1<sup>st</sup>, or within 30 days of becoming eligible for another health plan, in accordance with the provisions of the medical plan master plan description. I certify that the information on this form is true and complete. I understand that giving false or incomplete information may result in the retroactive loss of this coverage. I understand that I must work at least 30 hours per week to remain eligible for this medical plan. A photocopy of this shall be valid as the original.

**X** \_\_\_\_\_ DATE \_\_\_\_\_

EMPLOYEE SIGNATURE DATE

## OFFICE USE ONLY

New Client? Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Regular Enrollment <input type="checkbox"/> Qualifying Event Details: _____ <input type="checkbox"/> Late Enrollment	Coverage Effective Date: _____ 1 <sup>st</sup> Reviewer: _____ Review Date: _____ Client Number: _____
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