



**EMPLOYEE ENROLLMENT FORM**

Group Name: \_\_\_\_\_

**EMPLOYER INFORMATION (TO BE COMPLETED BY HR)**

Enrollment (check one):     New Enrollment     Change of Enrollment Status    Effective Date of Insurance/Change: \_\_\_\_\_

Enrollment/Change Reason:  
 New Employee     Rehired Employee     Open Enrollment     Transfer from Other Plan     Involuntary Loss of Other Coverage (Prior Coverage Certificate required)  
 Marriage     Divorce     Adoption (Legal Documents May be Required)     Dependent Change     Other Qualifying Event: \_\_\_\_\_  
 Date of Event: \_\_\_\_\_

Date of Hire: \_\_\_\_\_    Date Employee Entered Eligible Class (if not date of hire): \_\_\_\_\_    Employee Class: \_\_\_\_\_

Employee Hours Worked Per Week: \_\_\_\_\_    Job Title: \_\_\_\_\_

**EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)**

Employee Name: \_\_\_\_\_    Phone: \_\_\_\_\_    Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_    City: \_\_\_\_\_    State: \_\_\_\_\_    Zip: \_\_\_\_\_

Add	Drop	Relationship to Employee	Name (Last, First, MI)	Social Security Number (required)	Date of Birth	Gender	
						Male	Female
<input type="checkbox"/>	<input type="checkbox"/>	Self					
<input type="checkbox"/>	<input type="checkbox"/>	Spouse/Domestic Partner					
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
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<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

Is any child over the dependent age limit of 26, applying for coverage due to disability?     No     Yes    If yes, see Human Resources for additional paperwork.

**BENEFIT PLAN SELECTION (TO BE COMPLETED BY EMPLOYEE) Please only choose one election each for vision and dental.**

<b>Delta Dental Plans</b> (Complete if offered by employer)	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse/Domestic Partner	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Decline
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<b>Standard Insurance Company Vision Plans</b> (Complete if offered by employer)	<b>Enrollment Election:</b>				
	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse/Domestic Partner	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Decline

**Life/AD&D Insurance Beneficiary Information:**

Elect       Decline

Beneficiary Name	Relationship	Address	% of Benefit Payable to Beneficiary (must total 100%)

EMPLOYEE SIGNATURE In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. AGC Health Benefit Trust, BSI, and The Insurance Companies may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. The Insurance Companies may also disclose PPI to state and/or federal agencies, or other third parties, as required by law. This authorization, unless revoked earlier, expires 24 months after the date it is signed.

Employee Signature \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_