UNIVERSAL BENEFITS ENROLLMENT FORM

SECTION 1: Employer Name, Policy Info and Benefits Offered

Company Name:	Medical Dental	Vision Life/AD&D	Short Term Disability Long Term Disability	Voluntary Life, AD&D Worksite Voluntary
Insurer(s) and Policy #(s):				

SECTION 2: Employee Information

Name (Last, First, MI):	Social Security #:	Date of Birth:
Address (#, Street, Apt or Unit #)	City, State	Zip Code

Male Female	Single Married	Separated Divorced	Domestic Partner Widowed	Phone #:

Job Title:	Date of Hire:	Hours per week:	Email:

Employee Class (if applicable):	Work Location (City, State):	Pay: $_______________	Annually Hourly	Weekly Bi-Weekly

SECTION 3: Enrollment Transaction

New Hire	Benefits Eligibility Date(s):
Open Enrollment	Open Enroll Date(s):
Add Employee due to life event*	Life Event Date, Description:
Add Dependent(s) due to life event*	Life Event Date, Description:
Term Employee	Requested Term Date, Reason:
Term Dependent(s)	Requested Term Date, Reason:
Name Change due to life event*	Life Event Date, Description:
Elect COBRA/State Continuation	Effective Date, Reason:
Decline COBRA/State Continuation	Decline Reason:
Term COBRA/State Continuation	Requested Term Date, Reason:
Elect NJ Total Disability	Event Date:
Other:	Requested Date, Description:

**If requesting an enrollment, change or term due to a life event, proof of loss of coverage (certificate or letter from prior insurer(s) with names, coverage types and effective dates) and/or proof of the event (divorce decree, marriage certificate, etc.) must be attached to this form.*

SECTION 4: Enrollment Elections

Medical (name of the plan selected):	Single___	Ee + Sp___	Ee + Child(ren)___	Family___	Waive___
Dental (name for dual-dental plans):	Single___	Ee + Sp___	Ee + Child(ren)___	Family___	Waive___
Vision:	Single___	Employee + Spouse___	Employee + Child(ren)___	Family___	Waive___

		Primary Beneficiary(ies): total must = 100%	Contingent Beneficiary(ies): total must = 100%
Life/AD&D:	Elect ___	Name__________________Relation:________%___	Name_________________ Relation_______ %___
ST Disability:	Elect ___	Name__________________Relation:________%___	Name_________________ Relation_______ %___
LT Disability:	Elect ___	Name__________________Relation:________%___	Name_________________ Relation_______ %___

Vol Life/AD&D:	Elect ___	Amount:	Primary Beneficiary(ies):	Contingent:
Sp Vol Life/AD&D::	Elect ___	Amount:	Primary Beneficiary(ies):	Contingent:
Ch Vol Life/AD&D	Elect ___	Amount:	Primary Beneficiary(ies):	Contingent:

Worksite:	Accident ___	Cancer ___	Critical Illness___	Hospital ___	Short Term Disability ___	Life, AD&D___

SECTION 5: I am waiving medical and/or dental for myself and/or my dependents due to coverage through:

Spouse___	2nd job___	Parent___	COBRA___	Military___	Medicare ___	Medicaid ___	Other ___	None ___
If Spouse or Parent, is coverage through an employer?					If Other or None, explain:			
Medical Insurer:			Policyholder:			Policy #:		
Dental Insurer:			Policyholder:			Policy #		

*If you and/or your dependents are waiving medical and/or dental, this section **must** be completed.*

SECTION 6: Dependent Information

Relation:	Name (Last, First, MI):	M/F:	Social Security #:	Date of Birth:	Disabled?	Student?
Spouse Add Term		M F			Y N	Y N
Child 1 Add Term		M F			Y N	Y N
Child 2 Add Term		M F			Y N	Y N
Child 3 Add Term		M F			Y N	Y N
Child 4 Add Term		M F			Y N	Y N

If your medical plan requires referrals, please list your and your family's primary care dr(s) first and last name(s), city/state:

____

Will you and/or your dependents have other medical in force at the time this coverage starts? ____ If yes, indicate name(s) and provide the other medical policy #(s) and insurer name(s):____

If you included step-children, please indicate their name(s): ____

If any dependents do not reside with you, please indicate their name(s), reason(s), and address(es): ___________________

____

Are you or any of your dependents eligible for Medicare due to age (65 years or over)? _______ Disability (any age)?_______

If yes, please indicate their name(s) and attach a copy of their Medicare ID(s): ___________________________________

If you have more than 4 children, please attach an additional copy of this page. FT students: attach course schedule or tuition bill.

SECTION 7: Employee Signature

I certify that the information provided herein is complete and true. I understand that if any of the information was listed incorrectly, is missing or incomplete, that it is my responsibility to notify my employer immediately and in writing and that it is likely my coverage(s) will be impacted as a result and that any claims incurred may not be able to be processed until I do so. I further understand that my employer and/or the insurers may require legal documentation, such as a Social Security card, birth certificate, marriage certificate, etc. to process enrollment transactions and that I must provide whatever documentation is required if so. I agree that all of the information above represents my benefit elections/declinations at this time and I understand that if at any time I need to make changes to these elections due to a qualifying life event, changes in my or my family's eligibility for benefits, personal information, disability status, Medicare eligibility, Medicaid eligibility or student status, that I will notify my employer within 20 days. I have received a copy of, have read thoroughly through and fully understand all of my employer's benefits information including plan documents, rates, notices and disclosures, the ERISA wrap document, SBCs, SPDs, plan flyers, General Rights Notice, and Model Health Insurance Exchange Notice. Please accept my signature on this form in place of the insurer form(s) to enroll in/waive benefits as indicated herein:

_______________________________ _______________________________ ______________

Employee Signature | Printed Name | Date

SECTION 8: Employer Signature

I certify that I have reviewed and approve all information herein. Please process all requested transactions in conjunction with our in-force policies, waiting period and eligibility rules. If at any time this information must be corrected or changed, we will provide newly completed/signed forms and/or documentation within 20 days. Our company uses this universal form to record and transact enrollments in place of the insurer form(s):

_______________________________ _______________________________ ______________

Employer Signature | Printed Name, Title | Date