

## Benefits Election Form

### Open Enrollment / Change 2014 – 2015

Employee Name \_\_\_\_\_ Date \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Coverage Effective Date \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Reason for Change: \_\_\_\_\_

<p><b>Medical Coverage (Aetna)</b></p> <p>I elect Medical coverage for:</p> <p>_____ Employee Only</p> <p>_____ Employee &amp; Spouse</p> <p>_____ Employee &amp; Child(ren)</p> <p>_____ Family</p> <p>_____ I elect to waive medical coverage      Reason: _____</p> <p>Do you have any other health insurance?    <input type="checkbox"/> Yes                      <input type="checkbox"/> No</p> <p>Primary Care Physician Name: _____</p>	<p>HR Use Only Date Enrolled:</p>
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<p><b>Dental Coverage (MetLife)</b></p> <p>I elect dental coverage:</p> <p>_____ Employee Only</p> <p>_____ Employee &amp; Spouse</p> <p>_____ Employee &amp; Child(ren)</p> <p>_____ Family</p> <p>_____ I elect to waive dental coverage      Reason: _____</p>	<p>HR Use Only Date Enrolled:</p>
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<b>Dependent Information</b>				
<u>Name</u>	<u>SSN</u>	<u>Date of Birth</u>	<u>Relationship</u>	<u>Gender</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

X \_\_\_\_\_  
Employee Signature

For HR Use Only	
<b>MetLife</b>	<b>Life / AD&amp;D</b>
_____ 001 = 50,000	_____ 002 = 20,000
_____ STD / LTD	\$ _____ Annual Salary