SISTERS OF ST. JOSEPH
Baden, Pennsylvania

Benefits Election Form

Open Enrollment / Change 2017 – 2018

Employee Name _____ Date _____

Social Security # _____ Date of Birth _____

Coverage Effective Date _____ Date of Hire _____

Reason for Change: _____

Medical Coverage (Highmark)

HR Use Only
Date Enrolled:

I elect Medical coverage for:

_____ Employee Only _____ Employee & Spouse

_____ Employee & Child(ren) _____ Family

_____ I elect to waive medical coverage Reason: _____

Do you have any other health insurance? ☐ Yes ☐ No

Primary Care Physician Name: _____

Vision Coverage (Highmark)

HR Use Only
Date Enrolled:

I elect vision coverage:

_____ Employee Only _____ Employee & Spouse

_____ Employee & Child _____ Employee & Family

_____ Employee & Children

_____ I elect to waive vision coverage Reason: _____

Dental Coverage (United Concordia)

HR Use Only
Date Enrolled:

I elect dental coverage:

_____ Employee Only _____ Employee & Spouse

_____ Employee & Child(ren) _____ Family

_____ I elect to waive dental coverage Reason: _____

Dependent Information

Name	SSN	Date of Birth	Relationship	Gender

X _____
Employee Signature

For HR Use Only

Principal

____ 001 = 50,000

____ STD / LTD

Life / AD&D

_____ 002 = 20,000

$ _____ Annual Salary