SISTERS OF ST. JOSEPH
Baden, Pennsylvania

Benefits Election Form

Open Enrollment / Change 2019 – 2020

Employee Name _____ Date _____

Social Security # _____ Date of Birth _____

Coverage Effective Date _____ Date of Hire _____

Reason for Change: _____

Medical Coverage (Highmark)

☐ I elect Medical coverage as follows:

☐ I elect to WAIVE medical coverage

Select One

☐ **Community Flex $0 Enhanced Deductible**

☐ **Community Flex $500 Enhanced Deductible**

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Child(ren)

☐ Family

Do you have any other health insurance?

☐ Yes

☐ No

Who is your Primary Care Physician?

_____

Vision Coverage (Highmark)

☐ I elect vision coverage as follows:

☐ I elect to WAIVE vision coverage

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Child(ren)

☐ Family

Dental Coverage (MetLife)

☐ I elect dental coverage as follows:

☐ I elect to WAIVE dental coverage

☐ Employee Only

☐ Employee & Spouse

☐ Employee & Child(ren)

☐ Family

Dependent Information

Name	SSN	Date of Birth	Relationship	Gender

X _____

Employee Signature

For HR Use Only - Disability / Life / AD&D

____ 001 = 50,000 _____ 002 = 20,000

____ STD / LTD $_____ Salary