BLUE CROSS/BLUE SHIELD & MET LIFE 2021-2022 ENROLLMENT FORM

*Waive **Employee** Coverage:* ☐ YES ☐ NO	*Please provide reason for waiver:*

SECTION 1: Employee Information *(please complete this section even if you are waiving coverage)*

Last Name	First Name	Date of Birth (MM/DD/YY)	Social Security Number
Street Address	City	State	Zip Code
Primary Phone Number	Preferred Email Address		

SECTION 2: Dependent Information – Must be completed if dependents are covered under your benefit election

Last Name	First Name	Relationship	Gender	Date of Birth	Social Security Number	Disabled?	Check Coverage
						☐ YES ☐ NO	☐ MEDICAL-Children Only ☐ DENTAL ☐ VISION ☐ Dep Life
						☐ YES ☐ NO	☐ MEDICAL-Children Only ☐ DENTAL ☐ VISION ☐ Dep Life
						☐ YES ☐ NO	☐ MEDICAL-Children Only ☐ DENTAL ☐ VISION ☐ Dep Life
						☐ YES ☐ NO	☐ MEDICAL-Children Only ☐ DENTAL ☐ VISION ☐ Dep Life

SECTION 3: Benefit Elections

	BCBS MEDICAL PPO				BCBS DENTAL		METLIFE VISION	
Coverage Tier	Cost Per Pay Pd (26)	Election			Cost Per Pay Pd (26)	Election	Cost Per Pay Pd (26)	Election
Employee	$0.00	☐			$0.00	☐	$4.41	☐
Employee + Spouse	No spouse coverage on plan aft 6/1/15	☐			$14.20	☐	$8.39	☐
Employee + Child(ren)	$253.25	☐			$18.30	☐	$8.83	☐
Employee + Family	No spouse coverage on aft 6/1/15	☐			$36.70	☐	$12.98	☐

*Waive **Dependent** Coverage:* ☐ YES ☐ NO	*Please provide reason for waiver:*

ACKNOWLEDGMENT: My signature below indicates I have read the material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected before my income is calculated for tax purposes where appropriate. I understand that, based upon my filing status, I may receive additional tax credits under the IRS's Earned Income Credit Regulations. I further understand that: I will be given the opportunity once a year to decide on individual/Child(ren) coverage. Once made, my decision cannot be changed for a full year unless there is a change in child dependent status. If from year to year, I do not make changes; my coverage will stay the same with the new contribution automatically updated in my paycheck. I understand that I will be entitled to COBRA benefits if my employment is terminated. Coverage will begin based on the plan eligibility rules governed by actual plan documents. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualified change in dependent status. **I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do** hereby **agree to the conditions of enrollment set forth above. Signature is required in order to be a valid enrollment or waiver of coverage.**

Employee Signature: _____ **Date:** _____

HR Use Only:	Hire Date:	Effective Date:	Enrollment Change:	