BENEFITS ENROLLMENT
2017 - 2018

PERSONAL DATA

Employee Name (First, Middle Initial, Last)		Social Security Number		Date of Birth (MM/DD/YYYY)
Home Address		**City**	**State**	**ZIP Code**
Home Phone #	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Check all that applies:** ☐ Bargained ☐ Under 65 ☐ Non-bargained ☐ Over 65	**Email address**

DEPENDENT DATA

Name (First, MI, Last)	Relationship	Social Security Number	Birth Date MM / DD / YYYY	Gender
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female

NOTE: *Documentation must be provided when adding spouses and/or dependents - marriage license, birth certificate, etc.*

MEDICAL

AETNA

At the time of hire, or if you are already employed, please notify your employer of your plan election

KELSEY HMO - $750 DED	MEMORIAL HERMANN ACO - $1,000 DED	CHOICE POS II - $2,000 DED
☐ *no employee cost*	☐ *$0.50/hr through payroll deduction*	☐ *$1.25/hr through payroll deduction*

AUTHORIZATION

With this benefit election form, I hereby authorize my employer to make deductions from my paycheck for my Medical elections.
I understand that:

- I cannot change this election during the Plan Year unless I have a change in family status, (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse) and such other events as the Plan Administrator determines will permit a change or revocation of an election.
- During Open Enrollment of each year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new form, my current benefit elections will continue to be effective for the new Plan Year.

Employee Signature _____ ***Date*** _____

Return completed forms to: Maggi Vargas • mvargas@benefitresourcesinc.com • 713-643-9300 • Fax: 866-316-4794
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