BENEFITS ENROLLMENT

January 1, 2020 – December 31, 2020

****Please submit form regardless of any changes****

PERSONAL DATA

Employee Name (First, Middle Initial, Last)		**Last Four of 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	**Email address**

DEPENDENT DATA

Name (First, MI, Last)	**Relationship**	**Last Four of 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

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**	☐ **$1.00/hr through payroll deduction**	☐ **$4.00/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 • ggarcia@benefitresourcesinc.com • 713-643-9300 • Fax: 866-316-4794
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