PAGE
Providing Arizona's Greatest Education

EMPLOYEE BENEFITS ENROLLMENT FORM

Date of Hire:		Effective Date:		Payroll Schedule		PP Start	

Name:					
Gender:		Date of Birth:		Social Security #:	
Address:				City:	
State:	Zip:	Phone:		E-mail:	

ASBAIT GROUP MEDICAL INSURANCE

MONTHLY PREMIUM

I want Medical Insurance.	YES		NO		WAIVE/SIGNATURE			
MEDICAL PLANS	Classic Silver		Co-Pay Gold		HDHP			
COVERAGE	EMP ONLY		EMP & SPOUSE		EMP & CHILD(REN)		EMP & FAMILY	

DELTA DENTAL INSURANCE

MONTHLY PREMIUM

I want Dental Insurance.	YES		NO		WAIVE/SIGNATURE			
COVERAGE	EMP ONLY		EMP & SPOUSE		EMP & CHILD(REN)		EMP & FAMILY	

VSP VISION INSURANCE

MONTHLY PREMIUM

I want Vision Insurance.	YES		NO		WAIVE/SIGNATURE					
VISION PLANS	BASE		BUY-UP		COVERAGE	EMP ONLY		EMP+1		EMP+2

LIFE INSURANCE

MONTHLY PREMIUM

I want Life Insurance.	YES		NO		WAIVE/SIGNATURE	

COVERAGE TYPE					AMOUNT	PREMIUM
BASIC	YES		NO		CLASS 1: $100,000 / CLASS 2: $50,000	EMPLOYER PAID
DEPENDENT	YES		NO		$15,000 SPOUSE/$5,000 DEP	$2.52
VOL EMP LIFE+AD&D	YES		NO			
VOL SPOUSE LIFE+AD&D	YES		NO			
VOL DEP CHILD BEN	YES		NO		$10,000	$2.00

PRIMARY Beneficiary	NAME		SSN#	
Address			Relationship	
SECONDARY Beneficiary	NAME		SSN#	
Address			Relationship	

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DEPENDENT INFORMATION									
SPOUSE	NAME						COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL	VISION
CHILD	NAME						COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL	VISION
CHILD	NAME						COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL	VISION
CHILD	NAME						COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL	VISION
CHILD	NAME						COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL	VISION
CHILD	NAME						COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL	VISION

EMPLOYEE SIGNATURE DATE

PUSD HUMAN RESOURCES ONLY:					
	NEW HIRE	Hire Date		Effective Date	
	TERMINATION OF INSURANCE				
	CHANGE	Effective Date		Date of Qualifying Event	
	ADD/TERM DEPENDENT(S)				
	LEAVE OF ABSENCE	Start Date:			
	OPEN ENROLLMENT				
	RETIREE	Effective Date:			

SALARY		HR INITIALS		DATE	
DATE SENT TO FENDLEY		DATE ENTERED INTO VISIONS			