

EMPLOYEE BENEFITS ENROLLMENT FORM

Date of Hire:		Effective Date:		Payroll Schedule		PP Start	
Name:							
Gender:		Date of Birth:		Social Security #:			
Mailing Address:						City:	
State:		Zip:		Phone:		E-mail:	

ASBAIT GROUP MEDICAL INSURANCE	MONTHLY PREMIUM	
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I want Medical Insurance:	YES		NO		WAIVE/SIGNATURE				
MEDICAL PLANS	Value Gold		Classic Gold		HDHP				
COVERAGE	EMP ONLY		EMP & SPOUSE		EMP & CHILD(REN)		EMP & FAMILY		

DELTA DENTAL INSURANCE	MONTHLY PREMIUM	
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I want Dental Insurance:	YES		NO		WAIVE/SIGNATURE				
COVERAGE	EMP ONLY		EMP & SPOUSE		EMP & CHILD(REN)		EMP & FAMILY		

VSP VISION INSURANCE	MONTHLY PREMIUM	
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I want Vision Insurance:	YES		NO		WAIVE/SIGNATURE				
VISION PLANS	BASE		BUY-UP		COVERAGE	EMP ONLY	EMP+1	EMP+2	

LIFE INSURANCE	MONTHLY PREMIUM	
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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	

DEPENDENT INFORMATION

SPOUSE	NAME					COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL
CHILD	NAME					COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL
CHILD	NAME					COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL
CHILD	NAME					COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL
CHILD	NAME					COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL
CHILD	NAME					COVERAGE		
	SSN#		DOB		GENDER		MEDICAL	DENTAL

EMPLOYEE SIGNATURE

DATE

PUSD HUMAN RESOURCES ONLY:

	NEW HIRE	Hire Date		Effective Date		Employment Class	
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				