Benefits Enrollment Form 2021 (1 of 2)

Type of Enrollment

- O New Hire
- O Open Enrollment Change
- O COBRA—Reinstatement
- O Family Status Change

Family Status Change Reason:
Marriage_____
Newborn/Adoption_____
Court Ordered_____
COBRA_____
Loss/Gain of Other Coverage_____

- O Date of Hire _____
- O Date of Rehire_____
- O Benefits Eff. Date_____
- O Date of Term _____

Employee Information

Employee Name (Last, First, Middle)

Address (Street, City, State & Zip)

Social Security Number	Home Phone Number	Date of Birth	Gender (M/F)

Marital Status:
○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Full Time/Part Time

Medical

BBA Medical Coverage

- O **ELECT**
- O **WAIVE**

BBA Group 80827 Option

- O **Network Plan (EPO)**
- O **PPO Plan**

Medical Plan Coverage Level

- O Employee Only
- O Employee + Family

Dental

Delta Dental PPO + Premier

- O **ELECT**
- O **WAIVE**

Delta Dental Coverage Level

- O Employee
- O Employee + Family

Legal Assistance

MetLaw

- O **ELECT**
- O **WAIVE**

Vision

EyeMed Insight Plan Enrollment

- O **ELECT**
- O **WAIVE**

EyeMed Coverage Level

- O Employee
- O Employee + Family

Participant Information

Name—Last, first, middle	Social Security	Birth Date	Gender	PCP Name (not required)	PCP TIN (not required)
(Employee)					
(Spouse)					
(Child Dependent)					
(Child Dependent)					
(Child Dependent)					
(Child Dependent)					

Benefits Enrollment Form 2021 (2 of 2)

Reason for Waiver (if applicable)

If you are waiving coverage under the Haartz benefits plans, please specify why:

- O Spousal Coverage
- O MA Health
- O Medicaid
- O Medicare
- O Other (please specify): _____

Coordination of Benefits

Are you or a family member covered by another medical, dental or vision plan? If so, please indicate plan type and person's name.

O I am covered by another plan:

___ Medical: Plan Name_____

___ Dental: Plan Name_____

___ Vision: Plan Name_____

O My family member is covered by another plan:

___ Medical: Plan Name_____

___ Dental: Plan Name_____

___ Vision: Plan Name_____

Employee & Employer Authorization

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the plan, I will execute such assignments, liens, or other documents which may be necessary to enable the plan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for the services provided by the plan, I will immediately reimburse the health plan to the extent of the services provided, to the extent permitted by state law. I authorize the pre-tax and/or post-tax deductions and any adjustments required for participation in the Benefit Program.

The information provided on this form is true and correct to the best of my knowledge, and I accept the provisions listed within. I understand I will not be able to apply or make changes to my elections until the next open enrollment period, unless I have a family status change. I authorize the pre-tax and/or post-tax deductions required for participation in the plans I have elected on this form.

Employee Signature: _____ Date_____

Employer Signature: _____ Date_____