

ACSHIC Enrollment Form

Effective Date: _____ Phone #: _____

LAST NAME		FIRST NAME			MI
SOCIAL SECURITY NO.		DATE OF BIRTH (MM/DD/YYYY)		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married
ADDRESS		CITY		STATE	ZIP

Coverage Type	Election	Coverage Level				
Medical/RX	<input type="checkbox"/> EPO <input type="checkbox"/> PPO	<input type="checkbox"/> Individual	<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Family
Vision	<input type="checkbox"/>	<input type="checkbox"/> Individual	<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Family
Dental	<input type="checkbox"/>	<input type="checkbox"/> Individual	<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Family

Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. Any time a qualifying life event occurs, the employee needs to inform Human Resources within 30 days of occurrence in order to make a change to coverage.

I am opting out of all coverages. By checking this box, I understand that I will not be enrolled in any of the above coverages.

Dependent Election

	NAME	SSN	DATE OF BIRTH	GENDER	RELATIONSHIP	Medical/RX	Dental	Vision
1						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Enrollment Attestation

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled.

Authorized Employer Signature

Date

Employee Signature

Date