

# ACSHIC Enrollment Form

Effective Date: \_\_\_\_\_ Hire Date: \_\_\_\_\_

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

## 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"/>

*Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. For information on changes that outside of open enrollment please see the HIPAA Notice of Special Enrollment Rights.*

## Waiving Coverage

I decline to enroll in health coverage for  
 Reason for waiving coverage  Myself  My Spouse  My Dependent child/children  
 Other coverage  Other reason

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date, specifically, except during applicable "Special Enrollment Periods".

\_\_\_\_\_  
 Employee Signature                      Date                      Spouse's Signature                      Date

## 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