Benefits Enrollment, Change, and Termination Form

Employee Information

First Name | MI | Last Name | SSN

Address | Date of Birth | Phone

City | State | Zip Code

M!(male) | F (female) | X (nonbinary) | Married | Single | Separated/Divorced

Hire Date | Term/Retire Date (if applicable)

Section 1: HEALTH & WELFARE and ANCILLARY BENEFITS

Complete this column to ADD coverage for NEWHIRE or QUALIFYING EVENTS	Complete this column to END coverage DECLINE, DISCONTINUE, RESIGN, RETIRE, TERMINATE
☐ Medical – Anthem HDHP	☐ Medical – Anthem HDHP
☐ Dental – Superior Dental Care	☐ Dental – Superior Dental Care
☐ Vision – Anthem Blue View Vision	☐ Vision – Anthem Blue View Vision
☐ HSA - Health Savings Account with Chard Snyder	☐ HSA - Health Savings Account with Chard Snyder
☐ FSA Health Care	☐ FSA Health Care
☐ FSA Dependent Care	☐ FSA Dependent Care
☐ FSA Limited	☐ FSA Limited
☐ Basic Life/AD&D Insurance & Business Travel Insurance	☐ Basic Life/AD&D Insurance & Business Travel Insurance
☐ Supplemental Employee Life Insurance	☐ Supplemental Employee Life Insurance
☐ Supplemental Spouse or Child Life Insurance	☐ Supplemental Spouse or Child Life Insurance
☐ LTD Insurance	☐ LTD Insurance
☐ TIAA 403(b) Retirement	☐ TIAA 403(b) Retirement
Check the desired coverage level	Provide reason for discontinuing coverage:
☐ Employee	☐ Discontinue all members
☐ Employee + Spouse*	☐ Discontinue only for:
☐ Employee + Child(ren)	********** **HR USE** **********
☐ Family*	Effective Date:
*Eligible spouse must submit Spousal Evidence of Eligibility form	Payroll
To elect different coverage levels for different plans, specify here (ex: elect Family coverage for medical and Employee only coverage for Dental).	Anthem
	Chard Snyder
Indicate date of qualifying event:	MetLife
Indicate type of qualifying event:	Superior
	TIAA

Section 2: DEPENDENT INFORMATION

Dependent 1: Full Name _____ SSN _____ DOB _____

Gender: ☐ M ☐ F ☐ X ☐ Spouse ☐ Child/step-child/foster child

Dependent 2: Full Name _____ SSN _____ DOB _____

Gender: ☐ M ☐ F ☐ X ☐ Spouse ☐ Child/step-child/foster child

Dependent 3: Full Name _____ SSN _____ DOB _____

Gender: ☐ M ☐ F ☐ X ☐ Spouse ☐ Child/step-child/foster child

Dependent 4: Full Name _____ SSN _____ DOB _____

Gender: ☐ M ☐ F ☐ X ☐ Spouse ☐ Child/step-child/foster child

Dependent 5: Full Name _____ SSN _____ DOB _____

Gender: ☐ M ☐ F ☐ X ☐ Spouse ☐ Child/step-child/foster child

Dependent 6: Full Name _____ SSN _____ DOB _____

Gender: ☐ M ☐ F ☐ X ☐ Spouse ☐ Child/step-child/foster child

☐ I understand and agree with the following statements:

1. Only eligible spouses can enroll in medical coverage and if I enroll my spouse, I will submit a Spousal Evidence of Eligibility form.
2. My dependents are not eligible for any coverage for which I am not covered.
3. If there is a change to my, or my dependents, eligibility status I will notify the Wittenberg Human Resources department of the change within 30 days of the event.
4. If I decline benefit coverages, I and/or my dependents must wait until I become eligible for special enrollment rights or until the next Annual Enrollment period.
5. I authorize my employer to deduct my employee premium from my pay according to the elections made on this form.
6. I declare that the information I have completed on this form is true and complete.

Signature and Date: _____