

Please print and thank you for providing this information.

EMPLOYEE NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NO.	HOM	E PHONE	WORK	PHONE	
				()	()	
ADDRESS (Street)			(City)	<u> </u>	(5	State)	(Zip Code)	
I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS.		RELATION				IDER COVERAGE FULL TIME		FULL TIME
	me if different from yours)		SOCIAL SECU	RITY NO.	BIRTH	SELE	CTION	STUDENT?*
Last Name	FirstName	M.I.		Mo.	Day Year			Yes No
Employee		Self			М	Medical	Vision	
					F	Denta l		
Spouse*					М	Medical	Vision	
					F	Dental	¥101011	
Dependent *					М	Medical	Vision	
					F	Dental		
Dependent*					М	Medical	Vision	
					F	Dental		
Dependent *					М	Medical	Vision	
					F	Denta l		
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* To enroll a spouse provide a cop	py of your marriage certifica	nte; To Enroll Depend	ent child provide copy	of birth certificate				
MEDICAL OPTIONS:				VSP		METLIF		
	Emblem Option 1 with Welln	ess \ Waive N	ledical Coverage	VSP (VISION PLAN):			E _OPTION):	
MEDICAL OPTIONS: Emblem Option 1 - No Wellness	Emblem Option 1 with Wellne	ess Waive N	ledical Coverage					
Emblem Option 1 - No Wellness	Emblem Option 1 with Welln	ш	ledical Coverage	(VISION PLAN):	overage	(DENTAL	OPTION):	irane
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☐ Emblem Option 1 - No Wellness ☐ Emblem Option 2 - No Wellness	Emblem Option 2 with Wellne	ess	ledical Coverage	(VISION PLAN):	overage	(DENTAL	OPTION):	rage
Emblem Option 1 - No Wellness	_	ess	ledical Coverage	(VISION PLAN):	overage	(DENTAL	OPTION):	rage
☐ Emblem Option 1 - No Wellness ☐ Emblem Option 2 - No Wellness	Emblem Option 2 with Wellne	ess	ledical Coverage	(VISION PLAN):	overage	(DENTAL	OPTION):	rage
☐ Emblem Option 1 - No Wellness ☐ Emblem Option 2 - No Wellness	Emblem Option 2 with Wellne	ess	ledical Coverage	(VISION PLAN):	overage	(DENTAL	OPTION):	rage
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