Health Insurance Benefits Enrollment Form

Instructions: Please complete all sections of this form. This document is formatted for printing and manual completion or digital drafting.

1. Employee / Subscriber Information

Last Name:		First Name:	
Social Security Number:	XXX-XX-XXXX	Date of Birth:	MM/DD/YYYY
Street Address:			
City:		State & ZIP:	
Phone Number:		Email Address:	

2. Coverage Election

Please write the name of your selected Plan and your Coverage Level (e.g., Individual, Family, Employee + Spouse) in the fields below.

Selected Health Plan Option:	e.g., Standard PPO, High Deductible HSA
Coverage Level:	e.g., Employee Only, Employee + Spouse, Family

3. Dependent Information (If Applicable)

List all dependents to be covered under this plan.

Full Name	Relationship	Date of Birth (MM/DD/YYYY)	Social Security Number

4. Acknowledgment and Signature

By signing below, I certify that all information provided on this form is true and accurate to the best of my knowledge. I authorize payroll deductions for any premium contributions required for the coverage selected above.

Employee Signature (Sign on printout or type full name):		Date:	MM/DD/YYYY