Benefit Enrollment Form

Employee Details

Name: _____

Employee ID: _____

Department: _____

Start Date: _____

Benefit Options

1. Health Insurance
   - Plan Options: [Basic | Enhanced | Premium]
   - Coverage Start Date: _____
   - Signature: _____

2. Dental Insurance
   - Plan Options: [Basic | Enhanced | Premium]
   - Coverage Start Date: _____
   - Signature: _____

3. Vision Insurance
   - Plan Options: [Standard | Comprehensive]
   - Coverage Start Date: _____
   - Signature: _____

4. Retirement Savings Plan
   - 401(k) Contribution (% of salary): _____
   - Employer Match: [Yes | No]

- Signature: _____

Benefits Counseling

- Date of Counseling Session: _____
- Counselor's Name: _____
- Signature of Counselor: _____
- Signature of Employee: _____

Acknowledgement

I acknowledge that I have been provided with all necessary information regarding my benefits options and understand the implications of my selections.

- Date: _____
- Signature of Employee: _____