

Benefits Enrollment Form

- ☐ **New Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)
☐ **Late Enrollment** (Please refer to *Benefits Handbook* for rules on late enrollment.)
☐ **Open Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)
- ☐ **Change:**
☐ **Coverage** (Complete Parts A, B, C, D, F, G, H, I)
☐ **Health Plan** (Complete Parts A, B, D, H, I)
☐ **Name** (Complete Parts A, I)
☐ **Life Insurance Beneficiary** (Complete Parts A, E, F, I)
☐ **Optional Life Insurance** (Complete Parts A, F, I)

PART A Legal Marital Status: ☐ Married ☒ Not Married Sex: ☐ Male ☒ Female Date of Birth: 12/13/1988 Employment Date: 11/07/2010

Name: Love FIRST LAST CITY STATE ZIP CODE TELEPHONE E-MAIL ADDRESS
 412 Westland MI 48216 632 463 3410 lizlove@aol.com

Address: 11200 W. 11th Ave. Suite 100 Westland, MI 48216

PART B MEDICAL INSURANCE COVERAGE ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Name (Additional form required): ☐ Decline Coverage

Please choose one of the following:
☒ Employee Only ☐ Employee & Child(ren) ☐ Employee & Family ☐ Employee & Spouse or Domestic Partner (Requires additional documentation and approval)

PART C DENTAL COVERAGE ☒ Employee Only ☐ Family ☐ I Decline Coverage **VISION COVERAGE** ☒ Employee Only ☐ Family ☐ I Decline Coverage

PART D DEPENDENTS - COMPLETE IN FULL - LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM

ADD DELETE	LAST NAME	FIRST NAME	MI	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVERAGE
<input type="checkbox"/>								Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>
<input type="checkbox"/>								Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>
<input type="checkbox"/>								Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>
<input type="checkbox"/>								Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>

PART E BENEFICIARY DESIGNATION - BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE*

NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	ADDRESS	BENEFICIARY DESIGNATION
					Primary-Class 1 Contingent-Class 2
					Primary Contingent
					Primary Contingent
					Primary Contingent

*IMPORTANT: Please list your beneficiaries for your Basic Life and AD&D insurance. List additional beneficiaries on back of this form. Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. (If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise.)

PART F OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ☐ I Elect Coverage ☒ I Decline Coverage

Employee Paid - Submit within 60 days of hire or medical statement required Multiple of earnings 1X ☒ 2X ☐ 3X ☐ 4X ☐ 5X ☐ 6X ☐ 7X

List additional beneficiaries on back of this form. Beneficiaries will be the same as for Basic Life (Part E), unless you list different beneficiaries on the back of this form.

PART G DEPENDENT OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ☐ I Elect Coverage (Additional form required) ☒ I Decline Coverage

PART H MEDICAL INSURANCE PLAN CHANGE From: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan ☐ Decline Coverage To: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan ☐ Decline Coverage

DEPENDENT COVERAGE CHANGES Reason for change: ☐ Marriage ☐ Spouse's coverage terminated ☐ Newly eligible for coverage ☐ Child reached age limit ☐ No longer a student ☐ Divorce ☐ Birth/Adoption

PART I I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. Medical and dental insurance deduction is paid on a pre-tax basis unless a waiver form is submitted. (See Benefits Handbook for pre-tax medical insurance deduction information.)

EMPLOYEE SIGNATURE: Love Date: 11-17-17

Health Effective Date: Dental Effective Date: Vision Effective Date: Basic Life/AD&D Effective Date: Optional Life/AD&D Effective Date: NYS DBL Effective Date: LTD Effective Date: Campus Location: