

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

Name: Robert S Floyd D Date of Birth: 11/20/1955 Employment Date: 07/15/2016

Address: 20245 Hayes St. Livingia MT 48152 248 839-7011 RTfloyd@yahoo.com

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

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 checked="" type="checkbox"/>	<input type="checkbox"/>	Roberts	Milly	A	F	362-16-1055	11/11/1960	wife	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>	Roberts	John	H	M	397-15-1099	6/21/1999	son	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

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

NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	ADDRESS	BENEFICIARY DESIGNATION
Milly Roberts	100	wife	11/11/1960	20245 Hayes St. Livingia, MT 48152	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Contingent-Class 2 <input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Primary <input type="checkbox"/> 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

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

☒ I Elect Coverage ☐ I Decline Coverage

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 Date of change: ☒ I Elect Coverage (Additional form required) ☐ I Decline Coverage

☒ Open Enrollment From: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan ☐ Decline Coverage

☐ Moving out of area ☐ Decline Coverage ☐ Other

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 Floyd Roberts DATE 7/13/17

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