DEPENDENT ENROLLMENT FORM

INSTRUCTIONS

Enter dependent information below and attach required documentation from the DEPENDENT ELIGIBILITY DOCUMENTATION FORM. Documentation will be reviewed and if approved, your dependent will be added to plans indicated as of your effective date.

Documentation must be provided within 31 days of your effective date. If valid documentation is not received within the 31 days of your effective date, you will not be able to enroll your dependents until the next Open Enrollment period held in the Fall at which time documentation will then be required.

Fax your completed form to the Support Services Team at 732-751-7542 or contact Support Services at 732-751-3553 with any questions.

SECTION A - TEAM MEMBER PROFILE

Team Member Name: _____ **Location/Site:** _____

Team Member ID #: _____ **Daytime Phone #:** _____

SECTION B – DEPENDENT INFORMATION

Please include the information requested below for all dependent family members who will be covered under your benefit elections**.**
You must provide full-time student verification information for dependent child(ren) ages 19-23 for dental, vision and dependent life coverage only <u>every semester</u>.

Please check applicable coverage for each dependent.

First Name	Last Name	Social Security #	Date of Birth	Relation	Sex	Medical	Dental	Vision
				SPOUSE	☐M ☐F			
				CHILD	☐M ☐F			
				CHILD	☐M ☐F			
				CHILD	☐M ☐F			
				CHILD	☐M ☐F			
				CHILD	☐M ☐F			
				CHILD	☐M ☐F			

SECTION C – AUTHORIZATION

I have been provided with information relating to each of the above insurance options. I have reviewed this information and understand it. I authorize Meridian Health to reduce my salary by the agreed upon amounts indicated on this form to pay premiums for myself and/or my dependents on a pre-tax or after-tax basis depending upon the coverage(s) I selected above. I understand that due to provider and/or IRS regulations, my coverage elections are binding until either my employer changes the plan or the duration of the plan year, whichever comes first. I may only change my **coverage** elections during the plan year if I experience a **Qualifying Life Event**.

_____ _____

Team Member Signature **Date**

For Benefits Team:

□ Approved _____ Date to vendors: _____

□ Denied _____ Change effective date: _____

Reason: _____