

Benefit Election Form

Employer: Opportunities, Inc.		Group Number: (For internal use only)	
Employee Information:			
First Name	Middle Name	Last Name	
Street Address (Include House # and Apartment #)		City	State Zip Code
Date of Birth / /	Social Security #	Sex __ Male __ Female	Phone Number () -
Date of Employment / /	Annual Salary \$	Hours Worked Per Week	Work Location
Beneficiary Name (First, Last)		Beneficiary Relationship	
Email Address		Mothers Maiden Name (for security purposes)	
Dependents You Are Enrolling:			
Spouse Name	Social Security #	Date of Birth / /	Age __ Male __ Female
Child Name	Social Security #	Date of Birth / /	Age __ Male __ Female
Child Name	Social Security #	Date of Birth / /	Age __ Male __ Female
Child Name	Social Security #	Date of Birth / /	Age __ Male __ Female
Child Name	Social Security #	Date of Birth / /	Age __ Male __ Female
Child Name	Social Security #	Date of Birth / /	Age __ Male __ Female
Medical Plan (Check the plan(s) you wish to enroll in):		Optional Benefits (Check the plan(s) you wish to enroll in):	
MEC __ Employee \$15.05 Weekly __ Employee + Spouse \$22.03 Weekly __ Employee + Child(ren) \$37.17 Weekly __ Family \$44.15 Weekly __ Waive Coverage	Hospital Indemnity (Limited Medical)* __ Employee \$15.26 Weekly __ Employee + Spouse \$30.66 Weekly __ Employee + Child(ren) \$24.19 Weekly __ Family \$36.35 Weekly __ Waive Coverage	Dental Insurance __ Employee \$5.79 Weekly __ Employee + Spouse \$11.58 Weekly __ Employee + Child(ren) \$12.16 Weekly __ Family \$19.11 Weekly __ Waive Coverage	Vision Insurance __ Employee \$2.06 Weekly __ Employee + Spouse \$4.12 Weekly __ Employee + Child(ren) \$4.33 Weekly __ Family \$6.80 Weekly __ Waive Coverage
Please complete the paper application and submit it to Employee Relations If you have questions, please call 1-866-301-9375 & Select Option 1.		*You MUST elect Hospital Indemnity (Limited Medical) in order to elect Life Insurance and/or Short Term Disability.	
If you are waiving medical coverage, please indicate the reason: __ I currently have insurance elsewhere, either through spouse or parent's health care plan. __ I am covered through Medicare/Medicaid. __ I am declining coverage for other reasons.		Life Insurance* __ Employee \$2.12 Weekly	Short Term Disability* __ Employee \$3.71 Weekly

I have read the benefits packet and understand its limitations and exclusions. I understand that I will not have any insurance coverage for plans I did not elect above and that open enrollment is ONLY available for a limited time. I also understand that I have to enroll by my eligibility date and making NO benefit elections is a declination of coverage. I also understand I will not be able to re-enroll, make changes or cancel my coverage without a qualifying event/change of family status until the next open enrollment period. I will also read my policy upon receipt for a complete listing of limitations and exclusions.

SIGNATURE _____

DATE: _____/_____/_____