

Harris Kocher Smith Engineering - Employee Health Insurance Enrollment/Change Form

A. Employee Information-Type or print. Incomplete information will delay enrollment.

Last Name		First Name		M.I.	Social Security Number	
Mailing Address			City	State	Zip code	Date of Birth
Home Phone	Work Phone		Email		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Hire or Re-hire Date	Effective Date of Coverage or Change			Reason:		

B. Enrollment Information

Cigna Medical:	Enroll in Medical:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Family
	Waiving Medical *:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	Waiver Reason: _____
Humana Dental:	Enroll in Dental:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Family
	Waiving Dental *:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	Waiver Reason: _____
VSP Vision:	Enroll in Vision:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Family
	Waiving Vision *:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	Waiver Reason: _____

Member Information		Birth Date mo/day/yr	Social Security Number	Sex M/F	
List only members to be covered					
Last Name, First, M.I.					
Employee					<input type="checkbox"/> Add <input type="checkbox"/> Delete
Spouse					<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child					<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child					<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child					<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child					<input type="checkbox"/> Add <input type="checkbox"/> Delete

Use this space for additional notes or explanations if needed:

C. Coverage Changes

Cancellation: (Reason) Employment terminated (date) _____ Other coverage No longer eligible (FT to PT) Other
 Dependent Cancellations: Divorce/Legal Separation Other _____

Enrollment: (Reason) Open Enrollment New Hire (wait period applies) PT to FT (new hire wait applies) Qualifying Event (check event below)
 Qualifying Events (must be added within 30 days) Involuntary loss of other insurance Marriage Birth or Adoption of child

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my physician or me, or medical expenses which I have incurred may not be covered by my health benefit plan.

Signature of Employee _____ Date Signed _____

** If waiving coverage for myself or my dependents I understand that I (we) may not be eligible to enroll in the Harris Kocher Smith Engineering health plans until the next open enrollment period.*