Universal Enrollment & Change Form **Effective Date**_____

Reason for Enrollment:	
☐ New Hire Date	☐ Cobra ☐ Dependent Change (add/delete) ☐ Benefit Change/Cancel - Reason
☐ Open Enrollment	☐ Qualified Life Status Change Date: Event:

Part 1. Employee Information (please print)	
Name	SSN
Address	Date of Birth
City / State / Zip	Salary
Home Phone	Hours Per Week
Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced	Job Title

PART 2. PROVIDE INFORMATION ABOUT YOURSELF AND YOUR DEPENDENTS (PLEASE PRINT):
If you elect vision insurance for yourself and/or dependents, provide information below.
If dependent's address is different from employee, list address below. List additional dependents on separate page.

Name (List dependent address if different from employee)	**Social Security # REQUIRED**	**Date of Birth**	**Sex** M/F	**Vision**
Employee				☐ Enroll --- ☐ Waive
Spouse				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive
Child				☐ Enroll --- ☐ Waive

Please mark appropriate boxes below		
VISION ENROLLMENT ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	**BASIC LIFE ENROLLMENT** ☒ Employee ☒ Spouse ☒ Child(ren)	**STD ENROLLMENT** ☒ Employee Only

VOLUNTARY LIFE AND AD&D ENROLLMENT (Fee Schedule is found in the Employee Benefit Guide)

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EMPLOYEE ($10,000 up to $500,000) **SPOUSE** ($5,000 up to $250,000)

LIFE $_____ AD&D $_____ LIFE $ _____ AD&D $ _____

CHILD(REN)

☐ LIFE - $10,000 ☐ AD&D - $10,000

LIFE INSURANCE BENEFICIARY	**Primary Beneficiary, Relationship & Date of Birth** **Percentage %** 1._____ 2._____ **Contingent Beneficiary, Relationship & Date of Birth** 1._____ 2._____

Part 3. Read and complete authorization and sign form:

I hereby apply for group benefits(s) indicated above and understand I must be eligible as defined by the group plan, and my coverage will not take effect until I have completed the eligibility period (as defined in the group plan). Changes outside of my eligibility will only be allowed with a qualified life status change, otherwise I must wait for the next open enrollment.

I authorize my employer to withhold the required premium for the coverage(s) selected from my pay.

Employee Name (please print): _____

✍ **Employee Signature: _____ Date:_____**