

ACSHIC Enrollment Form

Effective Date: _____ Hire Date: _____

LAST NAME		FIRST NAME			MI
SOCIAL SECURITY NO.		DATE OF BIRTH (MM/DD/YYYY)		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married
ADDRESS			CITY	STATE	ZIP

Coverage Type	Election	Coverage Level				
Medical/RX	<input type="checkbox"/> EPO <input type="checkbox"/> PPO	<input type="checkbox"/> Individual	<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Family
Vision	<input type="checkbox"/>	<input type="checkbox"/> Individual	<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Family
Dental	<input type="checkbox"/>	<input type="checkbox"/> Individual	<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Family

Dependent Election

	NAME	SSN	DATE OF BIRTH	GENDER	RELATIONSHIP	Medical/RX	Dental	Vision
1						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. For information on changes that outside of open enrollment please see the HIPAA Notice of Special Enrollment Rights.

Waiving Coverage

I decline to enroll in health coverage for
Reason for waiving coverage

Myself My Spouse My Dependent child/children
 Other coverage Other reason

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date, specifically, except during applicable "Special Enrollment Periods".

Employee Signature Date Spouse's Signature Date

Enrollment Attestation

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled.

Authorized Employer Signature Date Employee Signature Date