Medical Insurance Benefit Election Form

Employee Name

Employee ID

Date of Birth

Email Address

Contact Number

Home Address

Plan Selection

○ Basic ○ Standard ○ Premium

Coverage Type

○ Employee Only ○ Employee + Spouse ○ Employee + Children ○ Family

List Dependents (if applicable)

Name, Relationship, Date of Birth

Desired Coverage Effective Date

Waiver of Coverage (if declining)

☐ I hereby decline medical insurance coverage.

Employee Signature

_____

Date