New Hire Health Benefits Enrollment

Personal Information

Full Name

Employee ID

Date of Birth

SSN (Last 4 digits)

Address

Phone Number

Email

Plan Selection

Select the benefit plans you wish to enroll in:

Medical

Dental

Vision

Life Insurance

Dependents

Full Name	Relationship	Date of Birth	Select Plan Coverage

Full Name	Relationship	Date of Birth	Select Plan Coverage
	-- Select --		☐ Medical ☐ Dental ☐ Vision
	-- Select --		☐ Medical ☐ Dental ☐ Vision

Beneficiary Information

Beneficiary Name

Relationship

Percentage

Authorization

☐ I authorize the above selections and understand the enrollment is subject to plan terms and conditions.

Signature

Date