Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ SSN: _____

Hire date: _____ Salary: _____

Email address: _____

Location of employment: _____

Dependents:

Name	DOB	Gender	Relationship

Beneficiaries:

Primary: _____ Relationship: _____ % _____

Primary: _____ Relationship: _____ % _____

Primary: _____ Relationship: _____ % _____

Primary: _____ Relationship: _____ % _____

Secondary: _____ Relationship: _____ % _____

Secondary: _____ Relationship: _____ % _____

Secondary: _____ Relationship: _____ % _____

Secondary: _____ Relationship: _____ % _____

Signature: _____ Date: _____

_____ I elect not to participate in dental, vision or voluntary life at this time.

NAME:_____

LOW DENTAL

EE only	$16.16
EE + 1	$29.80
EE + 2 or more	$45.60

HIGH DENTAL

EE only	$30.32
EE + Spouse	$58.12
EE + Child(ren)	$66.88
Family	$94.64

VISION

EE only	$8.40
EE + Spouse	$16.24
EE + Child(ren)	$13.96
Family	$21.76

VOLUNTARY LIFE

10,000.00	$ 2.26
20,000.00	$ 4.52
30,000.00	$ 6.78
40,000.00	$ 9.04
50,000.00	$ 11.30
60,000.00	$ 13.56
70,000.00	$ 15.82
80,000.00	$ 18.08
90,000.00	$ 20.34
100,000.00	$ 22.60
110,000.00	$ 24.86
120,000.00	$ 27.42
130,000.00	$ 29.68
140,000.00	$ 31.94
150,000.00	$ 34.50

DEPENDENT LIFE

5,000.00	$ 2.09
10,000.00	$ 4.17

SIGNATURE:_____ DATE:_____

I understand that should I elect to be covered under any of the plans above that I cannot change the deduction except to add or delete coverage due to a life change event (birth, marriage, loss of coverage, etc.) or at the open enrollment period. I also understand the guarantee issue period is only offered to new hires unless offered at open enrollment to increase existing coverage.