



Group Name	Requested Effective Date	Submission Date
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First Name	Last Name	Middle	Prefix	Suffix	Gender	Language
Social Security/Tax ID	Date of Birth	Phone (cell phone required for GHS)			Email (For plan information & ID cards)	
Street		City			State	Zip
Employee Number	Job Class	Payroll Frequency			Hire Date	

Dependents

Spouse First Name	Spouse Last Name	MI	Prefix	Suffix	Gender	Tax ID	Date of Birth
Child First Name	Child Last Name	MI	Prefix	Suffix	Gender	Tax ID	Date of Birth
Child First Name	Child Last Name	MI	Prefix	Suffix	Gender	Tax ID	Date of Birth
Child First Name	Child Last Name	MI	Prefix	Suffix	Gender	Tax ID	Date of Birth
Child First Name	Child Last Name	MI	Prefix	Suffix	Gender	Tax ID	Date of Birth
Child First Name	Child Last Name	MI	Prefix	Suffix	Gender	Tax ID	Date of Birth

Base Health Plan <input type="checkbox"/> MEC Basic/ASO MEC <input type="checkbox"/> Preventive HSA <input type="checkbox"/> Preventive Advanced <input type="checkbox"/> Waive If enrolling in Preventive HSA: HSA contribution amount _____ (monthly)	Enrollment Level <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	HealthShare Selection <input type="checkbox"/> \$1,000 IUA <input type="checkbox"/> \$2,500 IUA <input type="checkbox"/> \$5,000 IUA <input type="checkbox"/> Waive Pre-existing Conditions: (if any and enrolling) _____ _____ _____	Enrollment Level <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> Tobacco Use - \$50 added
Dental Plan <input type="checkbox"/> Copay Plan <input type="checkbox"/> Plus Plan <input type="checkbox"/> Waive	Enrollment Level <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	Vision Plan <input type="checkbox"/> Vision Plan <input type="checkbox"/> Waive	Enrollment Level <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family

By signing below, I affirm that the information above is correct and wish to enroll or waive as outlined above. I authorize the release of any medical information required to implement the plans selected. I also authorize the payroll deduction for any employee responsibility of the benefits selected. If enrolling in HealthShare, I agree to the Zion Health Principles of Membership.

Employee Name

Date