PLANSTIN

Group Name	Requested Effective Date	Submission Date

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	Enrollment Level	Catastrophic Selection	Enrollment Level
☐ Preventive Basic/ASO MEC ☐ Preventive Advanced ☐ Waive	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family	☐ HealthShare ☐ Waive Pre-existing Conditions: (if any and enrolling)	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Dental Plan	Enrollment Level	Vision Plan	Enrollment Level
☐ Copay Plan ☐ Plus Plan ☐ Waive	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family	☐ Vision Plan ☐ Waive	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ 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.

_____ _____

Employee Name Date