HEALTHEZ ADB Hoist Rings Mfg.

Benefit Enrollment / Change Form

Employee	**First Name:**	**M.I.**	**Last Name:**	**SSN:**	**Gender:** ☐ Male ☐ Female
	Mailing/Street Address:	**Apt./Ste.**	**City:**	**State:**	**Zip Code:**
	Birth Date:	**Hire Date:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced	**Phone Number:**	**Email:**

Enrollment	**Enrollment Type:**	☐ New Hire	☐ Open Enrollment	☐ Qualifying Event	☐ Decline (*See Decline Section*)
	Qualifying Event Type: (*If applicable*)	☐ Marriage / Divorce	☐ Birth / Death		☐ Court Order
		☐ Loss of Coverage	☐ Reduction in Hours		☐ Change Name / Address
		☐ COBRA	☐		☐

Medical	**Medical Plan Election:**	☐ Copay Plan	☐ Decline (*Complete Decline Section*)	
	Medical Plan Coverage:	☐ Employee Only	☐ Employee + Child(ren)	☐ Employee + Spouse	☐ Family

Dependents	**Name**	**SSN**	**DOB**	**Relationship**	**Sex (M/F)**	**Disabled (Y/N)**	**Include on Medical Plan**

Decline	☐ I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.

Other Insurance	**☐ I do not have other insurance coverage**	**☐ I have enrolled thru the state or federal Marketplace**
	☐ I have other insurance coverage	**☐ I have other insurance coverage, but intend to cancel that coverage**
	Policy Holder Name:	**Policy Holder Date of Birth:**
	Insurance Company Name:	**Insurance Company Address:**
	Policy Number:	**Group Number:**
	Names of Covered Individuals:	

Employee Authorization	☐ I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits. ☐ To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

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Employee Signature Date