Place Services

2016 / 2017 Election Form

First Name: ______________________ Last Name: ______________________ SSN: ______________

Gender __________ Date of Birth ______________ Phone ______________ Hire Date ______________

Address ______________________________ City ______________________ Zip ______________

Email ____

Please check the box next to each line of coverage you wish to elect or decline. Please write clearly.

Medical

	Humana NPOS Opt 4	Bi-Weekly
☐	Employee Only	$54.72
☐	Employee + SP	$109.45
☐	Employee + Child(ren)	$101.23
☐	Family	$258.38

	Humana NPOS Opt 12	Bi-Weekly
☐	Employee Only	$81.28
☐	Employee + SP	$187.44
☐	Employee + Child(ren)	$173.38
☐	Family	$371.06

☐ I Decline Medical Reason ____

Dependents To be on the Medical Coverage

Name ______________________ Date of Birth ______________________ SSN: ______________

Gender ______________ Relationship ______________

Name ______________________ Date of Birth ______________________ SSN: ______________

Gender ______________ Relationship ______________

Name ______________________ Date of Birth ______________________ SSN: ______________

Gender ______________ Relationship ______________

Name ______________________ Date of Birth ______________________ SSN: ______________

Gender ______________ Relationship ______________

By my signature below, I represent that all information on this application is correct. I direct my employer to deduct the amount of required contribution from my pay. I understand, and agree, that contributions will be taken out on a pre-tax basis subject to the IRS Section 125 Plan.

I understand that if I am waiving coverage now, I must experience a qualifying life event or wait until open enrollment next year to enroll.
Requests for status changes must be submitted within 30 days of the qualified event.

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Employee Signature Date Signed