ACSHIC Enrollment Form

Effective Date: _____ Hire Date: _____

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married

ADDRESS	CITY	STATE	ZIP

Coverage Type	Election	Coverage Level
Medical/RX	☐ **EPO** ☐ **PPO**	☐ Individual ☐ Parent/Child ☐ Parent/Children ☐ Employee/Spouse ☐ Family
Vision	☐	☐ Individual ☐ Parent/Child ☐ Parent/Children ☐ Employee/Spouse ☐ Family
Dental	☐	☐ Individual ☐ Parent/Child ☐ Parent/Children ☐ Employee/Spouse ☐ Family

Dependent Election

	NAME	SSN	DATE OF BIRTH	GENDER	RELATIONSHIP	Medical/RX	Dental	Vision
1						☐	☐	☐
2						☐	☐	☐
3						☐	☐	☐
4						☐	☐	☐

Open Enrollment is the time that you can make changes to your benefits outside of a qualifying life event. For information on changes that outside of open enrollment please see the HIPAA Notice of Special Enrollment Rights.

Waiving Coverage

I **decline** to enroll in health coverage for ☐ Myself ☐ My Spouse ☐ My Dependent child/children

Reason for waiving coverage ☐ Other coverage ☐ Other reason

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date, specifically, except during applicable "Special Enrollment Periods" .

_____ _____ _____ _____

Employee Signature **Date** **Spouse's Signature** **Date**

Enrollment Attestation

To the best of my knowledge, the information provided on these forms is true and correct. I understand that this form enrolls those eligible persons listed above in the selected plans and I authorize any payroll deductions required for the coverage I have selected. I also understand that I must select coverage for my dependents, or they will not be enrolled.

_____ _____ _____ _____

Authorized Employer Signature Date Employee Signature Date