

Employee Benefit Enrollment Form



Select Benefit Administrators PO Box 8339 Des Moines, IA 50301-8339

To be completed by Employer	Group Number: SFP		Location:		EE Classification:		Coverage Effective Date:			
	Employee Term Life: \$				Employee: \$					
	Dependent Term Life: \$				Disability Benefit? Yes <input type="checkbox"/> No <input type="checkbox"/>					
1. Employee Information	Last Name First Name Middle Initial			Date of Birth			Sex Male <input type="checkbox"/> Female <input type="checkbox"/>			
	Mailing Address			Social Security Number						
	City		State		Zip		Marital Status		Date Employed	
					Married <input type="checkbox"/> Unmarried <input type="checkbox"/>		Month		Date YR	
Employer Name			Job Title			Home Telephone No. ()				
2. Complete this section to indicate the persons to be covered and the desired coverage	Health Plan		Myself <input type="checkbox"/>		Spouse <input type="checkbox"/>		Child(ren) <input type="checkbox"/>		Decline* <input type="checkbox"/>	
	*If declining, are you enrolled in another health plan? Yes <input type="checkbox"/> No <input type="checkbox"/>									
	Dental Plan (if applicable)		Myself <input type="checkbox"/>		Spouse <input type="checkbox"/>		Child(ren) <input type="checkbox"/>		Decline* <input type="checkbox"/>	
	Other Plan (if applicable)		Myself <input type="checkbox"/>		Spouse <input type="checkbox"/>		Child(ren) <input type="checkbox"/>		Decline* <input type="checkbox"/>	
	If you are declining enrollment for yourself or your dependents because of other health coverage, you may in the future be able to enroll yourself or your dependents, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.									
	Dependent	Name			Birth Date		Age	Sex		Post High School Student?
	Spouse							Male <input type="checkbox"/> Female <input type="checkbox"/>		
	Child							Male <input type="checkbox"/> Female <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Child							Male <input type="checkbox"/> Female <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child							Male <input type="checkbox"/> Female <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Child							Male <input type="checkbox"/> Female <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Other Insurance Information	Is your spouse employed? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, name of employer							
	Does your spouse have a group health plan outside of this plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please indicate the coverage below.							
	Medical Plan <input type="checkbox"/>		Effective date:		Single Coverage <input type="checkbox"/>		Family Coverage <input type="checkbox"/>			
	Dental Plan <input type="checkbox"/>		Effective date:		Single Coverage <input type="checkbox"/>		Family Coverage <input type="checkbox"/>			
4. Health Insurance and Portability Act of 1996 Information	Did you have medical coverage prior to enrolling in this plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, Carrier Name: Effective date: Termination Date:							
	Type of Enrollment:		New Hire: <input type="checkbox"/>		Special Enrollment: <input type="checkbox"/>		Late Entrant: <input type="checkbox"/>			
	This group plan is required to provide a "Special Enrollment" period for individuals who do not enroll in the plan at their first opportunity but subsequently lose their other source of coverage for a reason other than voluntary termination of coverage, or for marriage, birth, or adoption. A "Late Entrant" is someone who did not enroll in the plan at his or her first opportunity, but now seek coverage without a "Special Enrollment" period.									
	Qualifying Event. A "Qualifying Event" is the event that triggers a Special Enrollment:									
	Enrollment Date:		The "Enrollment Date" is the first date of coverage, or if there is a waiting period, the first day the waiting period (usually the date of hire).							
	Is a Certification of Creditable Coverage Attached? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Select Benefit Administrators assumes that there is no creditable coverage. If a Certification of Creditable Coverage is provided, the plan pre-existing condition period, if applicable, may be partially or fully waived.									
5. Complete this information only if making a change.	<input type="checkbox"/> Name Change (Complete sections 1 and 8)									
	Former Name:				New Name:					
	<input type="checkbox"/> Change from Single to Family Coverage (Complete all sections)									
	Reason for change:		Date of change: Month		Date		YR			
	<input type="checkbox"/> Change from Family to Single Coverage (Complete sections 1, 2, and 8)									
	Reason for change:		Date of change: Month		Date		YR			
<input type="checkbox"/> Adding Dependents with no change in Coverage (Complete all sections)										
Reason for change:		Date of change: Month		Date		YR				
<input type="checkbox"/> Terminate a dependent (Complete section 1)										
Dependent(s) name:		Last date of Coverage: Month		Date		YR				
6. Premium Only Plan	Group sponsored insurance premiums may be funded with pre-tax dollars. I authorize my employer to reduce my salary by the employee contribution amount, as designated by my employer, to cover the premium for my employer sponsored insurance plans in which I have elected to enroll.									
	Employee Signature						Date			
7. Life insurance Beneficiary (if applicable)	I hereby make the following beneficiary designation. If more than one person is named, percentage of benefit rather than dollars should be used. The beneficiary for Dependent Life Insurance shall be the insured Employee if surviving. Otherwise, the Dependent's estate subject to the Group Policy provisions. If the designation is a trust, and the trustee is not a financial institution, please forward copy of trust agreement.									
	Beneficiary						Date			
8. Employee Signature	I understand that if I have made any false statements or misrepresentation or have failed to disclose or concealed any material fact SBA will be entitled to deny health care benefits. I agree that any surgeon, physician, dentist, pharmacist, nurse, hospital, or health care facility may furnish SBA with the diagnosis for any history of any past, present, or future treatments or conditions of all persons named herein. I agree, upon request, to furnish SBA with all information required to administer the health care plan. If the plan requires contributions by me, I authorize my employer to deduct them from my pay.									
	Employee Signature						Date			