Group Resources®
3080 Premiere Parkway, Ste 100
Duluth, GA 30097-4904

BENEFIT ENROLLMENT FORM

RATE CODE: _____

FOR EMPLOYER USE ONLY: HIRE DATE:_____ ORIIGINAL EFFECTIVE DATE: _____

EMPLOYER NAME: ECTOR COUNTY GROUP #: 4808

SECTION I - EMPLOYEE INFORMATION

Last Name:_____First:_____ _____ Initial _____

SSN:_____ Gender:_____ DOB: _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email:_____

SECTION II - MEDICAL/ DENTAL COVERAGE

□ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Employee + Family □ I decline coverage

Reason for Declination_____

If you Elect dependent coverage, please complete section below.

Dependent Name	SSN	Sex	DOB	Relationship	Is Dependent Employed?
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
If dependent is employed, is he/she eligible for coverage through a group health plan?					☐Yes ☐ No

If Yes is checked above, please complete the OTHER COVERAGE INFORMATION Section on back of form.

SECTION III- YOUR APPROVAL

I hereby apply for coverage under the benefit plan above. I authorize my employer to make necessary payroll deductions to cover the cost of participation in the selected plan. I understand this agreement shall remain in effect until such time as changed in writing.

SIGNATURE: _____DATE: _____

OTHER COVERAGE INFORMATION

IF YOU OR ANY OF YOUR DEPENDENTS HAVE MEDICAL OR DENTAL COVERAGE ELSEWHERE, YOU MUST COMPETE THIS SECTION AND PROVIDE A COPY OF YOUR INSURANCE CARD.

HEALTH PLAN INFORMATION

Insurance Company Name & Address: _____

_____

Name of Insured: _____ Identification # _____

Group Policy # _____ Certificate # _____

Effective Date of Coverage: Medical _____ Dental _____

Coverage is on: ☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Dependents Only

MEDICARE INFORMATION

Name of Insured _____ If eligible, is person enrolled in:

Federal Medicare Part A: ☐Yes ☐ No Part A Effective Date: _____

Federal Medicare Part B: ☐Yes ☐ No Part B Effective Date: _____