



Benefit Election Form

Company Name: _____

Name: _____

Hire Date: _____

Effective Dates: _____

Instructions:

Please indicate which benefits you wish to elect or waive by marking an X in the appropriate space. Please mark on EACH area – do not leave any blank.

	Enrolling	Declining	Not Applicable
Medical	_____	_____	_____
Dental	_____	_____	_____
Life	_____	_____	_____
STD	_____	_____	_____
LTD	_____	_____	_____

- If I am waiving any of the benefits, I understand that the next opportunity to enroll will be open enrollment of the following year. I also understand that if I have a life event change (marriage, divorce, and birth/adoption of a child, COBRA expiration), I will be able to enroll at that time.**

Signature _____ Date _____