BENEFITS ENROLLMENT FORM

EMPLOYEE NAME: _____ ☐ BT ☐ TH

STATUS: ☐ SINGLE ☐ MARRIED ☐ CIVIL UNION ☐ DOMESTIC PARTNER

HOME PHONE: _____ EMAIL ADDRESS: _____

POSITION: _____

HIRE DATE: _____ EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time

DO YOU OR YOUR SPOUSE HAVE HEALTH INSURANCE? ☐ NO ☐ Employee ☐ Spouse

If yes, list insurance carrier: _____

ARE YOU OR YOUR SPOUSE ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

If yes, list names of eligible person, Part A or Part B coverage, and effective dates of Medicare:

Name of Eligible Person	Check Coverage	Effective Date
	Part A ☐ Part B ☐	
	Part A ☐ Part B ☐	

HEALTH INSURANCE

☐ I decline health coverage thru BC/BS as I have coverage thru: _____

☐ I declined health coverage thru BC/BS and I have no other coverage

☐ I choose to be covered under BC/BS:

Coverage Type & Weekly Premium ☐ Single - $42 ☐ 2-Person - $70 ☐ Family - $86

Information about all family members you want enrolled under the plan:

	Name [1]	Relationship to Employee	M/F	Social Security Number	Date of Birth	Primary Care Physician
1		Employee				
2						
3						
4						
5						
6						
7						
8						

Coverage Note: Adult children may remain on the plan until their 26th birthday in some circumstances.

1. If any dependents reside outside of Vermont, please provide address on reverse side of this form.

VISION COVERAGE

Please check all boxes that apply.

- ☐ I have other vision coverage
- ☐ I need only Employee coverage
- ☐ I need Employee + 1 dependent ($0.70 weekly deduction)
- ☐ I need Employee + Family ($2.50 weekly deduction)

DENTAL COVERAGE

Please check all boxes that apply.

- ☐ I have other dental coverage
- ☐ I need dental coverage
- ☐ My dependents have other dental coverage
- ☐ My dependents need dental coverage (Not available at Terry Hill)

Signature: _____ Date: _____

DOMESTIC PARTNERSHIP

If you are in a domestic partnership, and you want to include health insurance coverage for your domestic partner, then both the employee and partner must complete an affidavit and provide evidence of the domestic partnership. Please check here ☐ if you want the domestic partnership information paperwork.

Out of State Dependents (Colllege Students):

Name _____

Address _____

_____

Name _____

Address _____

_____