mesa·az

BENEFIT ENROLLMENT/CHANGE FORM

Employer Section Information

□ Qualifying Event: _____ (Event Date)	□ Adding Dependent(s) □ Dropping Dependent(s) □ Adding Coverage □ Dropping Coverage		Benefit Effective Date: _____

Member Information

Last Name:	First Name: MI:		Employee ID:
Street:	City, State, Zip Code:		Date of Birth:
Home Phone:	Cell Phone:	Personal email:	SSN:

Medical/Prescription Drug Coverage Election (Choose One)

Plan Election: □ Basic Medical Plan (50/50) □ Choice Medical Plan (80/20) □ Copay Medical Plan (copay) □ Opt Out	Coverage: □ Member Only □ Member & Family

Dental Coverage Election (Choose one)

Plan Election: □ Preventive Choice (80/20) Max $1,000 □ Dental Choice (80/20) Max $2,000 □ Dental Choice Plus (80/20) Max $2,300 & Ortho □ Opt Out	Coverage: □ Member Only □ Member & Family

Vision Coverage Election (Choose One)

Plan Election: □ Basic Vision (12/24/24) □ Vision Plus (12/12/12) □ Premium Plus (12/12/12) □ Opt Out	Coverage: □ Member Only □ Member & Family

Dependent Information

Relationship	Gender	Last	First	MI	DOB (MM/DD/YYYY)	SSN
Spouse	□ M □ F					
Child □ Nat □ Step	□ M □ F					
Child □ Nat □ Step	□ M □ F					
Child □ Nat □ Step	□ M □ F					
Child □ Nat □ Step	□ M □ F					

Agreement and Signature

DOCUMENTATION IS REQUIRED IN ORDER FOR COVERAGE TO BE ACTIVATE OR DEACTIVATED (qualifying events must be submitted within 31 days): **Spouse**: Marriage Certificate; All Children: Birth Certificate(s). **Stepchildren, Adoption, Legal, Foster**: **Newborns**: Proof of birth from the hospital.

Signature:	Date:

For Office Use Only

Processed By: _____ Date: _____

Notes: _____

□ HRM □ Letter