Medical Benefits Enrollment Form

NOTE: Please Print except for Signature

Employee Information			SSN Required	
Employee Name (Last	First	Middle Initial)	Social Security Number / /	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY) / /
Street Address			Home Phone Number ( )	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed
City			Business Phone Number ( )	
State	Zip	Country	Occupation	

Dependent Information (Last name required if different from employee's)			SSN Rquired for all Dependents	
Spouse's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	Relationship ☐ Son ☐ Daughter Other_____
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	Relationship ☐ Son ☐ Daughter Other_____
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	Relationship ☐ Son ☐ Daughter Other_____

Other Insurance Information	
If you or any of your dependents are covered by other Group Insurance, please complete the following information.	
Name of Person covered by other insurance	Social Security Number / /
Name of Company this person works for	Group Number
Name of Insurance Carrier	

Employee Elections			
Apply For:	Medical Coverage:	Life: $50,000	Provider Network:
☐ Employee Only ☐ Employee + Spouse ☐ Employee +Child(ren) ☐ Employee + Family	☐ Comprehensive ☐ COB ☐ Basic ☐ Bronze Option	Life (ee and dep) AD&D (ee and dep)	Anthem Blue Cross JAA

Beneficiary Designation
Must Complete Reverse Side Beneficiary Designation Information

EMPLOYEE MUST SIGN HERE	
Employee Signature X	Date
E-mail address:	

HUB Office Use ONLY	
Dated Received: _____/_____/_____ Dated Processed: _____/_____/_____	Initials

Employer Use ONLY		
Name of Employer (District) Seeley Union School District		Employment Status ☐ Full Time ☐ Part Time ☐ COBRA
Employment Date	Initials	
Benefits Effective Date		Classification _____ ICSIS # _____