HBAA Enrollment / Change Form

Office Use Only	
Company Info.	Business Name: _____ Contact Name:_____ Phone:_____ Email:_____
Enrollment	☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ Qualifying Event
Change	☐ Personal Information ☐ Beneficiary ☐ Add Dependent ☐ Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	☐ Marriage/Divorce ☐ Birth/Adoption ☐ Court Order ☐ Loss of Coverage ☐ FT to PT (last day of FT Coverage _____)

Employee Information				
Social Security Number	Last Name		First Name	MI
Home Street Address Apt			City, State, Zip	
Date of birth	Date of hire	Gender (required) ☐ Male ☐ Female		

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

Elections						
Medical				Dental		Vision
High - Under 40	High - 40-49	High - 50+	Low Plan	Enhanced	Basic	
☐ Employee Only $672.16	☐ Employee Only $688.58	☐ Employee Only $724.26	☐ Employee Only $638.45	☐ Employee Only $31.22	☐ Employee Only $26.68	☐ Employee Only $9.37
☐ Employee + Spouse $1,324.07	☐ Employee + Spouse $1,356.05	☐ Employee + Spouse $1,428.79	☐ Employee + Spouse $1,257.89	☐ Employee + Spouse $61.47	☐ Employee + Spouse $52.37	☐ Employee + Spouse $13.20
☐ Employee + Children $1,235.08	☐ Employee + Children $1,259.59	☐ Employee + Children $1,293.98	☐ Employee + Children $1,166.49	☐ Employee + Children $81.05	☐ Employee + Children $68.65	Employee Children $13.41
☐ Family $1,885.12	☐ Family $1,919.20	☐ Family $1,993.64	☐ Family $1,785.93	☐ Family $121.11	☐ Family $103.09	☐ Family $19.78
☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____

I have read this form and the other materials given to me about my benefits and certify the information I have supplied is correct. I understand that misstatements, misrepresentations, or omissions may result in my coverage being canceled. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary action up to and including termination.

I also understand that the benefit coverages I elect on this form will be in effect for the entire plan year unless I experience a qualified status change event and request a change to my benefits within 30 days of such event. By signing and submitting this enrollment form, I authorize HBAA and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I understand that my contributions for the medical, dental and vision coverage (if elected) will be deducted pre-tax. I also understand that I am liable for these deductions pursuant to such authorization and acknowledge that it is my responsibility to verify that these payroll deductions are correct. I will notify human resources immediately in writing upon discovering any discrepancy.

Employee Signature: _____ Date: _____