



HBAA Enrollment / Change Form

Office Use Only	
Company Info.	Business Name: _____ Contact Name: _____ Phone: _____ Email: _____
Enrollment	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event
Change	<input type="checkbox"/> Personal Information <input type="checkbox"/> Beneficiary <input type="checkbox"/> Add Dependent <input type="checkbox"/> Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	<input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> 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) <input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
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Elections						
Medical				Dental		Vision
High - Under 40	High - 40-49	High - 50+	Low Plan	Enhanced	Basic	
<input type="checkbox"/> Employee Only \$672.16	<input type="checkbox"/> Employee Only \$688.58	<input type="checkbox"/> Employee Only \$724.26	<input type="checkbox"/> Employee Only \$638.45	<input type="checkbox"/> Employee Only \$31.22	<input type="checkbox"/> Employee Only \$26.68	<input type="checkbox"/> Employee Only \$9.37
<input type="checkbox"/> Employee + Spouse \$1,324.07	<input type="checkbox"/> Employee + Spouse \$1,356.05	<input type="checkbox"/> Employee + Spouse \$1,428.79	<input type="checkbox"/> Employee + Spouse \$1,257.89	<input type="checkbox"/> Employee + Spouse \$61.47	<input type="checkbox"/> Employee + Spouse \$52.37	<input type="checkbox"/> Employee + Spouse \$13.20
<input type="checkbox"/> Employee + Children \$1,235.08	<input type="checkbox"/> Employee + Children \$1,259.59	<input type="checkbox"/> Employee + Children \$1,293.98	<input type="checkbox"/> Employee + Children \$1,166.49	<input type="checkbox"/> Employee + Children \$81.06	<input type="checkbox"/> Employee + Children \$68.65	<input type="checkbox"/> Employee Children \$13.41
<input type="checkbox"/> Family \$1,885.12	<input type="checkbox"/> Family \$1,919.20	<input type="checkbox"/> Family \$1,993.64	<input type="checkbox"/> Family \$1,785.93	<input type="checkbox"/> Family \$121.11	<input type="checkbox"/> Family \$103.09	<input type="checkbox"/> Family \$19.78
<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> 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: _____