FOR HR DPT USE ONLY
NEW: _____ CHANGE:_____ Effective Date:_____________

BENEFIT ENROLLMENT FORM

Personal Information:	**Address:**	**Employment Information:**
Last: ______________	Street: ______________	____SW ____YL ____TBS ____HEC
First: ______________	______________	Title: ______________
Social Security: ______________	City: ______________	Location: ______________
Date of Birth: ______________	State: __________Zip: __________	Initial Employment Date: ______________
Gender: M___ F___ Marital Status: S___ M___	Email: ______________	

Dependent Information

Dependent #1:	Dependent #2:	Dependent #3:	Dependent #4:
Last: ______________	Last: ______________	Last: ______________	Last: ______________
First: ______________	First: ______________	First:______________	First: ______________
Social Security:______________	Social Security:______________	Social Security:______________	Social Security:______________
Date of Birth: ______________	Date of Birth: ______________	Date of Birth: ______________	Date of Birth: ______________
Relationship:	Relationship:	Relationship:	Relationship:
Spouse ____ Child ____ Other____	Spouse ____ Child ___ Other___	Spouse____ Child ____ Other____	Spouse____ Child ____ Other____

Medical- United Healthcare Per Month Deductions			**Dental- United Healthcare Per Month Deductions**			**Vision- VSP Per Month Deductions**		
Employee	$ 132.46	_____	Employee	$30.32	_____	Employee	$9.71	_____
Emp & Spouse	$ 662.27	_____	Emp & Spouse	$60.95	_____	Emp & Spouse	$15.53	_____
Emp & Child(ren)	$ 609.29	_____	Emp & Child(ren)	$65.84	_____	Emp & Child(ren)	$15.86	_____
Family	$ 1,297.94	_____	Family	$105.33	_____	Family	$25.56	_____
DECLINE For: ____Myself _____Spouse ____ Children			**DECLINE For:** ___Myself ____Spouse ____ Children			**DECLINE For:** ____Myself ____Spouse ____Children		

Previous Insurance: Within the last 18 months, have you or any covered family member had any medical coverage, such as Medicare or a Spouse's medical coverage?
___Yes ____ No **If Yes, list all:** Carrier Name(s): ______________________ Start Date: ______________ End Date ______________
Covered Members (check all that apply): ______Employee ______Spouse ______Child(ren)

ADDITIONAL INSURANCE OPTIONS

(Please fill out the appropriate form if you are interested in any of these options)

Accident – Voluntary _________ Short Term Disability _________
Cancer – Voluntary _________ Whole Life _________

Life Insurance: $10,000 Life & $10,000 ADD (Company Paid)		**FOR BENEFIT CHANGES ONLY – Qualifying Events**
Primary Beneficiary Last: ______________ First: ______________ SS#: ______________ Relationship: ______________	Secondary Beneficiary Last: ______________ First: ______________ SS#: ______________ Relationship: ______________	This form MUST be presented NO LATER THAN 30 DAYS after the event date indicated below. Written documentation of the qualifying event MUST be submitted with this change form. (If in doubt as to what type of documentation is required, call the HR Department at 713-784-6345.) **Examples of what constitutes a Status Change: Job Change (involving yourself or spouse), Marriage, Divorce, Death, Age Ineligibility, Birth or Adoption** *EVENT:______________ Date of Event:______________* *The effective date of change in coverage will be the 1st of the month following the date of the status change.*

****IMPORTANT NOTICE:** Once you sign up for any benefit, you CANNOT discontinue/change the coverage until the next open enrollment period (August) or within 30 days of a status change. **I authorize the above choices to be made and any appropriate premiums to be deducted from my earnings.**

Signature of Employee: ______________________________ **Date:** ______________________