



MLBMA Employee Benefit Plans, Inc.
EMPLOYEE ENROLLMENT/CHANGE FORM
 5815 Executive Drive * Suite A * Lansing, MI 48911 * Phone 517-394-5225 * Fax 517-853-0638

**Health
 Prescription (Rx)
 Dental
 Vision
 Life**

Section 1 **PLEASE PRINT ALL ANSWERS**

Company Name		Employee Name		
Date Employed	Occupation	Social Security Number (SS#)		
Address - Street	City	State	Zip	Employee Phone Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ___/___/___	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced

* If declining any offered benefit(s), please complete the waiver statement on the reverse side of this form.
 * If more than one health plan is offered by my employer, my choice is (print the plan name): _____.

Section 2 **LIFE INSURANCE BENEFITS - BENEFICIARY DESIGNATION**

First Name	Middle Initial	Last Name	Relationship
------------	----------------	-----------	--------------

Address (if different from employee)
 If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiaries (or beneficiary) as survive the insured, unless provided herein.
 If no designated beneficiary survives the Insured, settlement will be made to the Estate of the Insured, unless otherwise provided by the Group Contract.

Section 3 **LIST ALL DEPENDENTS ELIGIBLE FOR COVERAGE UNDER THE GROUP PLAN**

Add New or Delete Dependent*	Dependent Name	Date of Birth	Relationship	Dependent SS#
<input type="checkbox"/> add or <input type="checkbox"/> delete				
<input type="checkbox"/> add or <input type="checkbox"/> delete				
<input type="checkbox"/> add or <input type="checkbox"/> delete				
<input type="checkbox"/> add or <input type="checkbox"/> delete				

*Note: Please indicate the effective date of new or deleted dependent here: [_____]

Section 4 **STUDENT STATUS**

Please complete for any single dependents, age 19 to 25 who are full-time students.

Student Name	School Attending	Location	Year Attending

Section 5 **OTHER INSURANCE COVERAGE(S)**

Are you or any members of your family covered by another group insurance, Federal program for health coverage or health maintenance organization?
 Yes No If yes, name of policy holder: _____

Are you or any members of your family enrolled in Medicare? Yes No If yes, please attach copy of Medicare card(s) and check one of the following.
 Actively Working Retired Under 65 ESRD (End Stage Renal Disease)

Section 6 **SIGNATURE SECTION**

I certify that the information provided on this form is true and complete, and I agree to inform MLBMA Employee Benefit Plans if the information provided changes.
 Also, if contributions for my coverage is required, I authorize my employer to deduct my contributions for my benefits from my earnings until further notice.

Employee's Signature		Date Signed	
OFFICE USE ONLY			
Effective Date:	Health/Rx Plan:	Dental:	Open Enrollment:
Life Amount:	Optional Life:	Vision:	Special Enrollment:
Group #:	Dependent Life:	COBRA:	



MLBMA Employee Benefit Plans, Inc. EMPLOYEE WAIVER STATEMENT

5815 Executive Drive * Suite A * Lansing, MI 48911 * Phone 517-394-5225 * Fax 517-853-0638

Health
Prescription (Rx)
Dental
Vision
Life

PLEASE PRINT ALL ANSWERS

Company Name: _____

Employee Name: _____

SS#: _____

Please initial the appropriate line below and provide all applicable information:

If waiving coverage, please initial below which type of coverage you are waiving:

_____ I hereby waive **health/rx coverage** (employee & dependents) offered by this employer.

_____ I hereby waive **health/rx coverage** for my dependents only.*

_____ I hereby waive **dental coverage** (employee & dependents) offered by this employer.

_____ I hereby waive **dental coverage** for my dependents only.*

_____ I hereby waive **vision coverage** (employee & dependents) offered by this employer.

_____ I hereby waive **vision coverage** for my dependents only.*

_____ I hereby waive **optional life ins coverage** offered by this employer.

_____ I hereby waive **dependent life ins coverage** offered by this employer.

_____ **Requested Effective Date of Waiver (if applicable)**

***Note: If waiving coverage for a specific dependent but not all dependents, please indicate the name(s) of those waiving coverage: _____**

Please check the following reason that best describes why you are waiving coverage:

_____ I am covered under another group or individual (please circle one) health plan. The plan I am covered under is not offered by this employer.

The information for this coverage is as follows:

Carrier Name

Policy/Contract Number

Policyholder Name

Relationship to Employee

_____ I was not offered health care coverage by this employer.

_____ I do not want the group health care coverage offered through this employer because:

(please explain) _____

I certify that the information provided on this statement is true and complete, and I agree to inform MLBMA Employee Benefit Plans if the information provided changes.

Employee Signature

Date