

Employee Enrollment / Change Form

- Open Enrollment
- New Employee
- Qualifying Event



Employer	Employer Name Missouri Ozarks Community Action			Employee Job Location	
	Employee Date of Hire / /	Coverage Effective Date / /	Earnings	Hours Worked Weekly	Job Title

Employee	Name: Last		First	M.I.	Home Phone Number ()	
	Address			City	State	Zip
	Date of Birth / /	Gender	Marital Status		Social Security Number	

Elections	<input type="checkbox"/> I am making no changes to my benefits this year, please carry over current elections. (You do not need to fill out elections below)			
	Medical Base	Medical Buy Up	Dental Base	Dental Buy Up
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee
	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Spouse
	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Child(ren)
	<input type="checkbox"/> Family	<input type="checkbox"/> Family	<input type="checkbox"/> Family	<input type="checkbox"/> Family
<input type="checkbox"/> Waive	<input type="checkbox"/> Waive	<input type="checkbox"/> Waive	<input type="checkbox"/> Waive	
Voluntary Life Amount*	Matching Voluntary AD&D	Guaranteed Issue for Voluntary Life**		
<input type="checkbox"/> Employee _____	<input type="checkbox"/> Employee	Employee \$130,000		
<input type="checkbox"/> Spouse _____	<input type="checkbox"/> Spouse	Spouse \$50,000		
<input type="checkbox"/> Child(ren) _____	<input type="checkbox"/> Child(ren)	Child(ren) \$10,000		
<input type="checkbox"/> Waive All	<input type="checkbox"/> Waive All			
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto;"> If Electing Any Coverage For Any Dependents, You Must Complete the Dependent Information Section on Back </div>				
<input checked="" type="checkbox"/> Employer Paid Basic Life, \$20,000 Please Note: All Employees must complete the Beneficiary Designation section.				

*If electing more coverage than the guaranteed issue amount, Evidence of Insurability (EOI) form must also be submitted with application
 **Guaranteed issue amounts only apply to employees during initial eligibility period. Late entrants will need to submit an EOI for amounts over \$20,000. A late entrant is anyone who did not apply for Voluntary Life Insurance when first eligible.

Waiving Coverage	Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes.	
	<input type="checkbox"/> CERTIFICATION: I freely and voluntarily waive all coverage noted above for myself and my family. I fully understand that I will not be eligible to enroll into plans until Open Enrollment January 1, 2017, unless I experience a Qualifying Event.	
	_____	_____
	Employee SIGNATURE	DATE

Beneficiary Designation	If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.			
	Primary Beneficiary Name:	Percentage:	Relationship:	Phone:
	Secondary Beneficiary Name:	Percentage:	Relationship:	Phone:

Dependent Information	Spouse				SSN	Birthdate	Gender	
	Last Name	First Name	MI			/ /		
	Child(ren)				SSN	Birthdate	Gender	
	Last Name	First Name	MI			/ /		
	1							
2								
3								
4								
5								

COMPLETE THIS SECTION IF MAKING COVERAGE CHANGES OFF OF ANNUAL OR INITIAL OPEN ENROLLMENT

Qualifying Event	Effective date of change: _____	PLEASE SPECIFY APPROPRIATE QUALIFYING EVENT.
	<p>Life Events</p> <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of a Child <input type="checkbox"/> Adoption <input type="checkbox"/> Other: _____	<p>Loss of Coverage Due to</p> <input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction in hours worked <input type="checkbox"/> Death <input type="checkbox"/> Cessation of employer contributions <input type="checkbox"/> Other: _____

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that my deductions will be taken pre-tax and I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. Should I choose to have my deductions taken Post-Tax I must notify payroll prior to December 15th, 2015.

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

Employee SIGNATURE

DATE