

# EMPLOYEE BENEFIT ENROLLMENT FORM

## PALM BEACH COUNTY FIRE FIGHTERS EMPLOYEE BENEFITS FUND

This form is to be used for benefit elections that must be made within the first 30 days of eligibility. Please complete ALL of the employee information and check the appropriate boxes to your choices. This form must be signed by the Employee.

**EMPLOYEE INFORMATION: (PLEASE PRINT – ALL BLANKS MUST BE COMPLETED)**

Last Name	First Name	MI	Social Security Number			
Street Address					Area Code & Phone #	
City	State	Zip Code	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Marital Status	Date of Marriage
Employment Date	Occupation	High Risk <input type="checkbox"/> Yes <input type="checkbox"/> No		Annual Wages/Salary or Hourly		

**Please list ALL eligible dependents (including spouse if applicable) to be enrolled.**

Last Name (if Different)	First Name	Social Security #	Date of Birth	Sex	Relationship	Is Dependent a Student?	Is Dependent Disabled?	Coverage	
								Medical	Dental

Spouse's name	Social Security #	Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If there is other insurance coverage, please indicate address of carrier:
	Date of Birth		

Do you, your spouse, or dependent(s) have other <i>Group Coverage</i> or <i>Medicare</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, carrier name: _____	Please circle the appropriate response (Yes or No) regardless of coverage requested. Are you covered by: <b>Medicare:</b> Y or N <b>Other Medical:</b> Y or N <b>Other Dental:</b> Y or N Is your spouse covered by: <b>Medicare:</b> Y or N <b>Other Medical:</b> Y or N <b>Other Dental:</b> Y or N Are your dependents covered by: <b>Medicare:</b> Y or N <b>Other Medical:</b> Y or N <b>Other Dental:</b> Y or N
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### PREVIOUS HEALTH CARE COVERAGE

Please attach a copy of HIPAA Certificate of Continuous Coverage for credit (if applicable). This will assure proper credit toward any pre-existing condition limitation under this Plan.

### INDICATE TYPE OF COVERAGE YOU DESIRE:

**Medical Plan (PPO)**

None     Employee Only     Employee & Family

**Dental Plan DP**

None     EE Only     EE + SP     EE + CH(REN)     EE + SP + CH(REN)

**Rejection of any Medical, Dental, or Vision benefits does not eliminate automatic participation in the Life Insurance benefit.**

All information provided is true, accurate, and complete to the best of my knowledge.	
Participant Signature X _____	Date: _____
<b>TO BE COMPLETED BY EMPLOYER</b>	
Is employee actively working full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Date of Retirement: _____	
<b>Effective Date:</b> _____	
Employer Authorizing Signature _____	