AGA Enrollment / Change Form

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

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

Elections					
Premier Medical	**VALUE PLUS**	**Silver Medical**	**Enhanced Dental**	**Basic Dental**	**Vision**
☐Employee $733.67	☐Employee $701.99	☐Employee $658.93	☐ Employee $38.00	☐ Employee $31.00	☐Employee Only $11.23
☐ Employee + Spouse $1,467.24	☐ Employee + Spouse $1,397.54	☐ Employee + Spouse $1,302.81	☐Employee Spouse $75.00	☐ Employee + Spouse $60.00	☐Employee Spouse $15.56
☐ Employee + Children $1,345.99	☐ Employee + Children $1,287.38	☐ Employee + Children $1,207.72	☐ Employee + Children $94.00	☐ Employee + Children $58.00	☐Employee + Children $15.80
☐Family $2,079.6	☐Family $1,982.97	☐Family $1,851.64	☐ Family $142.00	☐ Family $108.00	☐Family $23.03
☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ 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 my employer and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. 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: _____