



AGA Enrollment / Change Form

Office Use Only

Company Info.	Business Name: _____ Contact Name: _____ Phone: _____ Email: _____
Enrollment	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event
Change	<input type="checkbox"/> Personal Information <input type="checkbox"/> Beneficiary <input type="checkbox"/> Add Dependent <input type="checkbox"/> Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	<input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> 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) <input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Information

Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Elections					
Premier Medical	Value PLUS	Silver Medical	Enhanced Dental	Basic Dental	Vision
<input type="checkbox"/> Employee \$775.75	<input type="checkbox"/> Employee \$740.91	<input type="checkbox"/> Employee \$693.54	<input type="checkbox"/> Employee \$38.00	<input type="checkbox"/> Employee \$31.00	<input type="checkbox"/> Employee \$11.23
<input type="checkbox"/> Employee + Spouse \$1,552.90	<input type="checkbox"/> Employee + Spouse \$1,476.23	<input type="checkbox"/> Employee + Spouse \$1,372.03	<input type="checkbox"/> Employee + Spouse \$75.00	<input type="checkbox"/> Employee + Spouse \$60.00	<input type="checkbox"/> Employee + Spouse \$15.56
<input type="checkbox"/> Employee + Children \$1,423.85	<input type="checkbox"/> Employee + Children \$1,359.38	<input type="checkbox"/> Employee + Children \$1,271.75	<input type="checkbox"/> Employee + Children \$94.00	<input type="checkbox"/> Employee + Children \$58.00	<input type="checkbox"/> Employee + Children \$15.80
<input type="checkbox"/> Family \$2,201.04	<input type="checkbox"/> Family \$2,094.74	<input type="checkbox"/> Family \$1,950.28	<input type="checkbox"/> Family \$142.00	<input type="checkbox"/> Family \$108.00	<input type="checkbox"/> Family \$23.03
<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> 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: _____