



ALVMA HEALTH TRUST

# ALVMA Enrollment / Change Form

Office Use Only	
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	Salary \$

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

Elections						
Medical				Dental		Vision
Platinum (includes secondary)	Gold	Silver (includes secondary)	Bronze	Enhanced	Basic	Vision (VSP)
<input type="checkbox"/> Employee Only \$618.65	<input type="checkbox"/> Employee Only \$696.49	<input type="checkbox"/> Employee Only \$580.88	<input type="checkbox"/> Employee Only \$536.32	<input type="checkbox"/> Employee Only \$27.41	<input type="checkbox"/> Employee Only \$23.29	<input type="checkbox"/> Employee Only \$11.35
<input type="checkbox"/> Employee + Spouse \$1,284.03	<input type="checkbox"/> Employee + Spouse \$1,447.36	<input type="checkbox"/> Employee + Spouse \$1,203.19	<input type="checkbox"/> Employee + Spouse \$1,107.80	<input type="checkbox"/> Employee + Spouse \$54.85	<input type="checkbox"/> Employee + Spouse \$46.58	<input type="checkbox"/> Employee + Spouse \$16.37
<input type="checkbox"/> Employee + Child(ren) \$1,056.95	<input type="checkbox"/> Employee + Child(ren) \$1,176.15	<input type="checkbox"/> Employee + Child(ren) \$985.99	<input type="checkbox"/> Employee + Child(ren) \$902.26	<input type="checkbox"/> Employee + Child(ren) \$71.29	<input type="checkbox"/> Employee + Child(ren) \$60.01	<input type="checkbox"/> Employee + Child(ren) \$16.65
<input type="checkbox"/> Family \$1,788.15	<input type="checkbox"/> Family \$2,039.47	<input type="checkbox"/> Family \$1,683.02	<input type="checkbox"/> Family \$1,558.96	<input type="checkbox"/> Family \$103.51	<input type="checkbox"/> Family \$87.63	<input type="checkbox"/> Family \$25.00
<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:	<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 ALVMA and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I understand that my contributions for the medical, dental and vision coverage (if elected) will be deducted pre-tax. 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: \_\_\_\_\_