



ALVMA Enrollment / Change Form

Office Use Only	
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	Salary \$

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

Elections						
Medical				Dental		Vision
Platinum (includes secondary)	Gold	Silver (includes secondary)	Bronze	Enhanced	Basic	Vision (VSP)
☐ Employee Only \$696.23	☐ Employee Only \$810.25	☐ Employee Only \$653.24	☐ Employee Only \$595.41	☐ Employee Only \$27.41	☐ Employee Only \$23.29	☐ Employee Only \$11.35
☐ Employee + Spouse \$1,448.88	☐ Employee + Spouse \$1,688.53	☐ Employee + Spouse \$1,356.88	☐ Employee + Spouse \$1,233.07	☐ Employee + Spouse \$54.85	☐ Employee + Spouse \$46.58	☐ Employee + Spouse \$16.37
☐ Employee + Child(ren) \$1,192.74	☐ Employee + Child(ren) \$1,370.68	☐ Employee + Child(ren) \$1,111.98	☐ Employee + Child(ren) \$1,003.31	☐ Employee + Child(ren) \$71.29	☐ Employee + Child(ren) \$60.01	☐ Employee + Child(ren) \$16.65
☐ Family \$2,016.90	☐ Family \$2,380.75	☐ Family \$1,897.25	☐ Family \$1,736.23	☐ Family \$103.51	☐ Family \$87.63	☐ Family \$25.00
☐ Decline Reason: _____	☐ 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 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: _____