METROCORP 2015 Medical Enrollment Form

A. Employee Information	Group Number 1111806	Effective Date:

New enrollment	Drop/Add Dependent	Drop Coverage	Personal Info Change	Open Enrollment

Employee Name (First MI Last):	Social Security Number:	Date of Birth:

Street Address:	Sex: M F	Occupation:

City:	State:	Zip Code:	Date of Hire:

Marital Status: M S D W	Date of Marriage:	Spouse Employed FT? Yes No	# of eligible children:

MEDICAL	COVERAGE LEVEL	COMPANY	H.S.A. CONTRIBUTION
Plan-PPO Plan- H.S.A. Plan-H.S.A. (low deductible) Waive Coverage	Employee Employee/Spouse Employee/Children Family	*Philadelphia* magazine *Boston* magazine Metrocorp	Amount per pay (does not apply to PPO) $ _____

B. Family Information

Relationship:	Dependent's Full Name:	DOB:	Sex:	Social Security Number:	Full Time Student:	Disable Dependent:
Spouse					N/A	N/A
Child					yes no	yes no
Child					yes no	yes no
Child					yes no	yes no

C. Waiver of Medical Coverage

I decline to enroll for medical coverage for myself, my spouse and my dependent children due to

Existence of other health coverage **Spousal Coverage** **Other reason** _____

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after event. I have read and understand the important information located on this form.

X _____ Date Signed: _____

D. Signature of Employee

I confirm that the information I have provided on this form is complete and accurate. I understand that the health benefit plan that I have selected provided reimbursement for certain medical costs, which are more fully described in the Summary Plan Description. I understand there may be instances where treatment decisions made by physician or me or medical expenses which I have incurred may not be covered by my health benefit plan. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that may be valuable to me and otherwise as permitted by law. I understand that you may combine information with other information so that is no longer individually identifiable to me and use it for commercial and other purposes; I acknowledge that I have received this information.

X _____ Date Signed: _____