



**Add:**       New Hire  
**Change:**     Address  Name  Health  Dental  Vision  
**Life Event:**  Marriage  Dependent Add/Term     Other  
**Life Event Date:** \_\_\_\_\_

**ENROLLMENT FORM FOR BENEFIT COVERAGES**

**Section I. – Employee Information**

Social Security Number		Last Name		First Name		MI
Address		City	State	Zip	Phone Number	
Date of Birth mm/dd/yyyy	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Hourly/Annual Earnings	Date of Hire (start date)	Effective Date	King's Employee Id#

**Section II. – Enrollment/Dependent Information**

	Name (Last/First/MI)	Gender	Date of Birth mm/dd/yyyy	Social Security Number	Enrollment (check all that apply to each member)
SELF		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Term		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent <input type="checkbox"/> Add <input type="checkbox"/> Term		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent <input type="checkbox"/> Add <input type="checkbox"/> Term		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent <input type="checkbox"/> Add <input type="checkbox"/> Term		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent <input type="checkbox"/> Add <input type="checkbox"/> Term		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision

**Section III. – Bi-Weekly Payroll Contributions**

		<u>Single</u>	<u>Parent/Child(ren)</u>	<u>Husband/Wife</u>	<u>Family</u>	<u>Waive</u>
Highmark BCBS	PPO Value Plan \$300	<input type="checkbox"/> \$57.00	<input type="checkbox"/> \$142.00	<input type="checkbox"/> \$167.00	<input type="checkbox"/> \$202.00	<input type="checkbox"/>
Highmark BCBS	PPO Core Plan \$500	<input type="checkbox"/> \$86.00	<input type="checkbox"/> \$213.00	<input type="checkbox"/> \$240.00	<input type="checkbox"/> \$301.00	<input type="checkbox"/>
Highmark BCBS	PPO Premier Plan \$150	<input type="checkbox"/> \$115.00	<input type="checkbox"/> \$256.00	<input type="checkbox"/> \$299.00	<input type="checkbox"/> \$378.00	<input type="checkbox"/>

**Dental Coverage - Please choose one election for Dental**

Single                     \$10.51  
 Employee + 1          \$19.05  
 Family                    \$27.86  
 Waive Participation   

**Vision Coverage - Please choose one election for Vision**

Single                     \$1.57  
 Family                    \$4.38  
 Waive Participation   

**King's College HR Office Use Only**

Faxed to Creative Benefits      
 Entered on Pink Sheets

Continued on Reverse

**Section IV. – Beneficiary Information**

Social Security Number	Name (Last, First)	Relationship	Type	Percentage (Must total 100%)
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

**Section VI. – Guardian Life, AD&D and Long Term Disability**

- Long Term Disability Coverage
- Life Insurance Coverage
- Voluntary Life Insurance Coverage\*
  - \* Voluntary Life Insurance is in addition to the company paid benefit.
  - \* If electing Voluntary Life you must complete a **Guardian Application**.
- I do not wish to elect Voluntary Life Insurance coverage at this time

**Section VI – Signature**

**Please note that all medical, dental, and vision payroll deductions will be taken on a pre-tax basis by King's College unless otherwise instructed.**

I understand that I cannot change or revoke my election for the medical, dental or vision coverage's as of any date prior to the next open enrollment period unless I notify my Human Resources office within 30 days of a qualified change in status. The information provided above is true and correct to the best of my knowledge and I accept the provisions that I have read and understood.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**If you have any questions about completing this form, please call Creative Benefits, Inc. at 1-866-306-0200  
Or contact via email at [ESR@creativebenefitsinc.com](mailto:ESR@creativebenefitsinc.com)**

