Beloit College

Human Resources
726 Church Street
Beloit, WI 53511
Phone: (608) 363-2630
Fax: (608) 363-2221

Benefits Enrollment/Change Form

Medical, Dental, Vision

1. EMPLOYEE INFORMATION			
Name (Last, First, MI)	**Date of Birth:**	**Social Security #**	
Mailing Address (Street, City, State, Zip)	**Phone:**	**Gender:**	**Date of Hire:**

2. CHANGE IN STATUS/QUALIFIYING EVENT (if applicable)			
Date of Qualifying Event/Change in Status:	☐ Marriage ☐ Gain of other Coverage ☐ Loss of other Coverage	☐ Birth/Adoption ☐ Divorce ☐ Death	☐ Change in dependent eligibility status ☐ Open Enrollment ☐ Other: ______________________

➢ ***This form must be completed, signed and returned at your new hire orientation meeting. If benefit elections are not made and the enrollment form is not returned within 30 days of hire, you will not be eligible to enroll until the next Open Enrollment period. Open Enrollment occurs annually with a Jan 1 effective date.***

Anthem Medical - Group #00254011	Anthem Dental Group #053107	Superior Vision
☐ New ☐ Drop ☐ Change ☐ No Change	☐ New ☐ Drop ☐ Change ☐ No Change	☐ New ☐ Drop ☐ Change ☐ No Change
☐ Employee Only ☐ Employee + Spouse/Same Sex Partner ☐ Employee + Child(ren) ☐ Family	☐ Employee Only ☐ Employee + Spouse/Same Sex Partner ☐ Employee + Child(ren) ☐ Family	☐ Employee Only ☐ Employee + Spouse/Same Sex Partner ☐ Employee + Child(ren) ☐ Family
☐ **Decline Medical Coverage** Reason for decline: ________________________________	☐ **Decline Dental Coverage** **Reason for decline:** __________________________________	☐ **Decline Vision Coverage** **Reason for decline**___________________________

3. DEPENDENT INFORMATION

Dependents	Name	Date of Birth	SS#	Gender M/F	Action: *(Add/Drop)*	Select Coverage
Spouse/Same Sex Partner					☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision
Child					☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision
Child					☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision
Child					☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision
Child					☐ Add ☐ Drop	☐ Medical ☐ Dental ☐ Vision

-Over-

4. DEPENDENT AUTHORIZATION & ACKNOWLEDGEMENTS – *If you are dropping a spouse or same sex partner and/or dependent child(ren) currently covered under the selected plan(s), each covered individual age 18 or over must also sign below.*

This is to certify that I am voluntarily dropping my coverage under the Beloit College health, dental, and/or vision insurance plan(s). I understand that in the event I should decide to reapply for such coverage at a later date, coverage will be subject to the applicable terms and conditions of each plan and may require additional limitation and waiting periods.

____________________________________ ___________________________
Signature of Spouse/Domestic Partner **Date**

____________________________________ ___________________________
Signature of Dependent Child **Date**

____________________________________ ___________________________
Signature of Dependent Child **Date**

____________________________________ ___________________________
Signature of Dependent Child **Date**

____________________________________ ___________________________
Signature of Dependent Child **Date**

5. EMPLOYEE AUTHORATION & ACKNOWLEGMENTS

I hereby certify that I have read the above statements or that they have been read to me and that the above statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

I hereby make the above elections and I authorize Beloit College to deduct the appropriate amounts from my pay for the coverages elected. I also hereby authorize the appropriate providers to release any documentation necessary to pay me or my dependents' claims.

I understand it is my responsibility to inform the Human Resources office of desired changes in coverage and/or changes in my family status or personal information that affects my benefit coverage or eligibility within 30 days of the event.

____________________________________ ___________________________
Signature of Employee Date

HR Office only:

____ Health 1 ____ Health 2 ____ Sub Group