Employee Name: _____ Date: _____

Employee Address: _____

Social Security Number: _____ Employee Number_____

Effective Date of Change: _____Effective Date of Termination: _____

Please select the appropriate level of coverage you desire.

- ☐ **Coverage Level Desired:**
  - **EE= $7.93**
  - **EE + Spouse= $15.07**
  - **EE + Children= $15.86**
  - **EE + Family= $23.31**

Complete the information for dependents to be covered according to the level selected above:

Spouse:

Last Name: _____ First Name: _____

DOB: _____ Social Security Number: _____

Children:

1. **Last Name: _____ First Name: _____**

DOB: _____ Social Security Number: _____

2. **Last Name: _____ First Name: _____**

DOB: _____ Social Security Number: _____

3. **Last Name: _____ First Name: _____**

DOB: _____ Social Security Number: _____

4. **Last Name: _____ First Name: _____**

DOB: _____ Social Security Number: _____

Employee Signature:_____ Date:_____