EMORY

☐ **Check here if your address has changed**

_____
Affiliate or Organization Name

AFFILIATE ELECTION FORM

EMPLOYEE INFORMATION

Name (Last, First, MI.)	**Hire Date**	**Last Four Digits of Social Security Number**
Street Address		**City/State/Zip**
Home Phone	**Alternate Contact Number**	**E-mail**

HEALTH BENEFITS

MEDICAL PLAN & COVERAGE LEVEL

☐ **I decline medical coverage**

☐ **I select the POS Plan**

Medical Plan Coverage Level:

- ☐ Single
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Family

DENTAL PLAN

☐ **I decline dental coverage**

☐ **I select the Aetna Traditional Dental (PPO) Plan**

☐ **I select the Aetna DMO Plan**

Aetna DMO Provider ID#: _____

DENTAL PLAN COVERAGE LEVEL

- ☐ Single
- ☐ 2 Person
- ☐ Family

PERSONAL INFORMATION

	Last Name **First Name** **MI.**	**Date of Birth** MM / DD / YY	**Gender**	**Relationship**	**Last 4 Digits of Social Security #**	**Medical** (please mark box)	**Dental** (please mark box)
Employee:				Self		☐ Yes ☐ No	☐ Yes ☐ No
Spouse:						☐ Yes ☐ No	☐ Yes ☐ No
Child(ren):						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

SIGNATURE (PLEASE READ CAREFULLY AND SIGN BELOW)

If I elect medical coverage, I authorize all hospitals, health care providers, pharmacists, employers, insurers, and all other entities to release medical, prescribed drugs, alcohol, substance abuse, employment and coverage records which pertain to me or my covered dependents to the Emory Benefit Plan(s) or its representatives. This information will be used in connection with benefit coverage and will be kept strictly confidential. This authorization shall remain valid for the term of this coverage unless I revoke it in writing. I understand that if I or my covered dependent is injured through the act of omission of another, the Emory Benefit Plan(s) will require reimbursement for the benefits provided in an amount not to exceed any damages collected. Typed name will suffice for a signature.

Signature/
Type Name: Date:

(HR Use Only)

Accepted by: _____ HR Data Entry Init.: _____ Date: _____

Send completed form to: Benefits Department, Human Resources, 1599 Clifton Road, First Floor, Atlanta, GA 30322; FAX: 404-727-7145; EMAIL: hrbenef@emory.edu