

EMPLOYEE INFORMATION

Name (Last, First, MI.)	Last Four Digits of Social Security Number	PeopleSoft ID (HR Use Only)
Street Address		City/State/Zip
Home Phone	Alternate Contact Number	E-mail

HEALTH BENEFITS

MEDICAL PLAN <input type="checkbox"/> Aetna HSA Plan <input type="checkbox"/> Aetna POS Plan <input type="checkbox"/> Kaiser Permanente Plan Coverage Level: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> I decline medical coverage	FLEXIBLE SPENDING ACCOUNT <input type="checkbox"/> Healthcare FSA Annual pledge: \$ _____	DENTAL PLAN <input type="checkbox"/> Aetna Traditional Dental Plan (PPO) <input type="checkbox"/> Aetna DMO Coverage Level: <input type="checkbox"/> Employee Only <input type="checkbox"/> 2-Person <input type="checkbox"/> Family <input type="checkbox"/> I decline dental coverage	VISION PLAN <input type="checkbox"/> EyeMed Vision Care Plan Coverage Level: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family <input type="checkbox"/> I decline vision coverage
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PERSONAL INFORMATION (attach additional pages, if necessary)

	Last Name	First Name	MI.	Date of Birth MM / DD / YY	Gender	Relationship	Medical (please mark box)	Dental (please mark box)	Provider ID# (DMO only)	Vision (please mark box)
Employee:						Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse:							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child(ren):							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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/ Typed Name:	Date:	(HR Use Only) Accepted by: _____ HR Data Entry Init.: _____ Date: _____
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