

TRUSTEE 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

- ☐ I decline medical coverage
- ☐ I select POS Plan coverage

MEDICAL PLAN COVERAGE LEVEL

- ☐ Trustee Only (under 65)
- ☐ Trustee Only (over 65)
- ☐ Trustee & Spouse (both under 65)
- ☐ Trustee & Spouse (1 over 65, 1 under 65)
- ☐ Trustee & Spouse (both over 65)
- ☐ Trustee & Family (both under 65, with dependents)
- ☐ Trustee & Family (1 over 65; 1 under 65, with dependents)
- ☐ Trustee & Family (both over 65, with dependents)

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)
Trustee:						Self		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse:								<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

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 as signature.

Signature:

Date:

(HR Use Only) Accepted by:	HR Data Entry Init.:	Date:	HR Billing Entry:	Date:
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