Part-Time Employee Health Care Plan Enrollment Form

For office use only:
Location #:
Group #:

Group Name: Beacon Mobility ***Date of Hire:*** _____ ***Effective Date:*** 6/1/2022

Employee Information (Please Print):

Employee Name (Last, First, MI): _____ Social Security Number: _____

Home Address: _____ Date of Birth: _____

City, State, Zip: _____ Gender: ☐ Male ☐ Female

Home Phone: (___) ___ - _____ Cell Phone: (___) ___ - _____ Email: _____

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family ☐ Waive

Plan Selected:
☐ **Pro Care Basic Plan with 1800MD** (Per paycheck deduction: $34.76, EE+SP: $54.09, EE+CH: $54.67, Family:$74.00)
☐ **Primary Care Plan PLUS with Health Care 2U Direct Primary Care** (Per paycheck deduction: $58.85, EE+SP: $95.03, EE+CH:$116.38, Family: $155.55)
☐ Waive

NAME of Covered Dependents First, Middle, Last		Gender Circle One	Date of Birth Month / Day / Year	Social Security Number	Enrolled in Another Plan? Circle One
SPOUSE		M F			Yes No
Child 1		M F			Yes No
Child 2		M F			Yes No
Child 3		M F			Yes No
Child 4		M F			Yes No

WAIVER OF MEDICAL COVERAGE (complete this section ONLY if you wish to WAIVE the Limited Plan)
This is to certify that I have been given an opportunity for group coverage available to me and my family members through my employer and I have decided to waive my right to coverage, at this time, because:
❒ I and / or my family members are covered by other group insurance.
❒ Other (Explain): _____

I certify that the information provided on this form is true to the best of my knowledge. I authorize my employer to deduct the required contributions from my earnings for my coverage.

Employee Signature: _____ **Date :** _____

FORMS ARE DUE BY
WED, MAY 18
Please give forms to your manager

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