EMPLOYER SECTION
Group No: __________ **Effective Date:** _________
Location:__________ **Date of Hire:** ___________
HR Rep./Date: _________________________

Benefits Enrollment Form

This enrollment form should be used to indicate your benefit elections or changes.
Please print and mark all selection boxes clearly.

MUST Select One:	☐ **New Enrollment**	☐ **Open Enrollment**	☐ **Add / Drop Dependent**	☐ **Drop / Change Coverage** ___/___/___

Section 1: Employee Information

Full Name (First MI Last): ____ Sex: ☐ M ☐ F
Address: ____ Social Security No.: _________-______-_________
____ Date of Birth: ______/______/______
City: ________________________ State: ______ Zip: __________ Home Phone: (_______) ________________
Mobile Phone:(_____)________________
Marital Status: ☐ Single ☐ Married, Date of Marriage: ______/______/______ ☐ Legally Separated ☐ Divorced

E-Mail Address:____

Section 2: Medical / Prescription Drug (Rx) Plan

Plan Option 1	
☐ Employee Only	☐
☐ Employee & Children	☐
☐ Employee & Spouse	☐
☐ Employee & Family	☐
☐ No Coverage (select this box to waive/cancel)	☐

Section 3: Dependent Information

	Full Name (First MI Last)	Date of Birth	Sex	Social Security No.	Permanently Disabled Child?	
Spouse		/ /	M F	- -		
Child		/ /	M F	- -	☐ Y	☐ N
Child		/ /	M F	- -	☐ Y	☐ N
Child		/ /	M F	- -	☐ Y	☐ N
Child		/ /	M F	- -	☐ Y	☐ N

Section 4: Other Insurance Information

Do you or any dependents listed have coverage under another benefit plan? ☐ No ☐ Yes. Complete the following:

Name of Policyholder: ______________________________ Name of Sponsoring Employer: ____________________
Name of Insurance Plan: ____________________________ Type of Plan: ☐ Group ☐ Individual
Type of Coverage: ☐ Medical ☐ Medicare ☐ Champus
List covered Dependents from Section 3 above: ____

Section 5: Employee Authorization and Acceptance

I hereby certifiy that I have read the **reverse side** of this enrollment form and agree to the terms of each Benefits Program that I am offered.

Print Name: ____

Employee Signature: ____ Date: ___________________

Benefits Authorization

I hereby apply for the coverages for which I am entitled under the terms of the employer's Benefits Programs and I agree to pay any required costs. I understand my employee contributions for the Benefit Plans will automatically be deducted from my paycheck on a before-tax basis from year to year, unless I notify the HR Department in writing otherwise and that, if offered, Flex Spending requires a new election each year. I also understand I cannot change my elections during the year unless I have a Qualified Change in Family Status or I meet the plans Special Enrollment requirements.

I authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance, reinsurance company, employer or third-party administrator having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policy holder, the plan sponsor, The Loomis Company - Benefits Division, or its legal representative any and all such information. Any medical information obtained will not be released to any person or organization except for those associated with our benefits programs, unless lawfully required to receive it.

I acknowledge that I may request a copy of this Authorization. I furthermore acknowledge that a photographic copy of this authorization shall be as valid as the original.

In the event I elected to waive/cancel my enrollment at this time in one of the Benefit Plan options, I understand I cannot enroll at a later date unless I meet one of the following provisions: 1) meet the Special Enrollment Requirements under HIPAA; 2) experience a Qualified Change in Family Status; 3) enroll during the Annual Open Enrollment Period. I understand my employer has HIPAA Privacy Information available should I need further information about the law and how it affects me and my family.

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is committing a fraudulent act which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT - PLEASE SIGN THE FRONT SIDE OF THIS ENROLLMENT FORM AS YOUR ACKNOWLEDGEMENT AND ACCEPTANCE OF THE ABOVE INFORMATION.