



## Telesearch

### 2024 - 2025 Enrollment Change Form Plan Year December 1, 2024, through November 30, 2025

#### DIRECTIONS:

1. Complete Sections 1 through 4. If you are waiving any lines of coverage, please be sure to check off the appropriate box.
2. Sign and Date the form.
3. Please return completed Enrollment form to **Karrie Rank** within 48 hours of receipt.

Please note that if you fail to provide notification within 31 days of a qualified life event change, you may not be able to enroll yourself or your dependents or change your current elections until the next open enrollment period.

#### 1. Employee Information *Please Provide ALL requested information. Check here if change of address*

Full Name:		Social Security Number:		Marital Status	
Address:			Date of Birth:		Gender:
City:		State:		Zip:	
Email Address:		Phone Number:		Occupation	
					Effective Date:

#### 2. Type of Enrollment *Please check all that apply.*

<input type="checkbox"/>	New Hire Enrollment	<input type="checkbox"/>	Birth or Adoption of Child	Date:
<input type="checkbox"/>	Open Enrollment	<input type="checkbox"/>	Divorce / Legal Separation	Date:
<input type="checkbox"/>	Address or Name Change	<input type="checkbox"/>	Spouse Lost or Gained Coverage	Date:
<input type="checkbox"/>	Other <i>(Please indicate)</i>	<input type="checkbox"/>	Marriage	Date:

#### 3. Coverage Options *Please check one box for each benefit – rates listed are monthly amounts.*

Carrier	Plan Name	Waive		EE Only		EE +Child		EE + Children		EE + Spouse		EE + Family	
AmeriHealth	EPO Value Plus	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	\$471.23	<input type="checkbox"/>	\$925.54	<input type="checkbox"/>	\$925.54	<input type="checkbox"/>	\$1,126.23	<input type="checkbox"/>	\$1,668.14
Have you or a dependent used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Please write name of the tobacco user													
If yes, are you participating in a tobacco cessation program										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No





## 4. Dependent Coverage Options

Please provide ALL information and check all boxes that apply.

Add	Delete	Dependent Full Name	Social Security #	Relationship	Birth Date	Gender	Medical
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>

I hereby declare that the information that I provide on this form is accurate and complete. I wish to participate in the benefit plan(s) that I have selected above, and I authorize my employer to deduct the necessary contributions from my paycheck. I understand that Social Security benefits may be reduced as certain pay deductions are being taken on a pre-tax basis. Further, my employer reserves that right to change the contributions at any time for the benefits they offer.

X \_\_\_\_\_  
Employee Signature

X \_\_\_\_\_  
Date

**Please complete this form Sign/Date and Deliver to:**  
Karrie Rank

Federal regulations prohibit you from changing your enrollment or your elected salary reduction amount during the Plan Year. The only exception is in the event you experience a change in family status called a Qualifying Life Event. A Qualifying Life Event refers to: marriage, divorce, the death of a spouse or dependent, the birth or adoption of a child, termination, or commencement of employment for your spouse, the changing of a part-time or full-time status for you or your spouse or taking an unpaid medical leave of absence by either you or your spouse. The beneficiary designation that you have made with the most recent calendar date will be considered your beneficiary designation. If you have not named a beneficiary, your Term Life Benefit will be payable to your estate.

Any coverage's that you elected which are subject to Evidence of Insurability (EOI) will not become effective until approved by the insurance carrier. Payroll deductions for the coverage amount pending EOI review will not begin until the review process is complete, and the coverage amounts are approved. If approved, the effective date of coverage will be indicated in written confirmation from the carrier. Similarly, if any of your elections add dependents to the plan and documentation (such as full-time student verification) is required by the carrier, the election will not take effect until such documentation is provided. Lastly, all amounts elected and/or approved are limited by the benefit maximums of each respective plan.

