Personal History Statement & Health/Dental/Vision Enrollment

Section 1: Please be as thorough and accurate as possible in completing this form. As a condition of employment, it is your responsibility to notify Human Resources and your supervisor whenever changes occur in this information.

Employee Name: ______________________________ DOB: __________

Address: ______________________________ SSN: __________

City/State/Zip: ______________________________

Phone: ____________________ Personal Email: ____________________

Emergency Contact Information

Name: ______________________________ Relationship to you: __________

Address: ______________________________ Best phone number: __________

Place of work: ______________________________ Alternative number: __________

Equal Employment Opportunity Commission Information

Disclosure of the following information regarding ethnic background is VOLUNTARY, but sharing this information allows us to comply with Federal reporting procedures and evaluate the effectiveness of our commitment to hire qualified minorities.

Race/Ethnicity:

_______ *White (non-Hispanic or Latino*
_______ *American Indian or Alaskan Native*
_______ *Black or African American*
_______ *Asian or Pacific Islander/Native Hawaiian*
_______ *Hispanic or Latino*
_______ *Other/Multiple races (please list):*
____

Marital Status:

_______ *Married*
_______ *Single*

Gender:

_______ *Male*
_______ *Female*

Section 2: Please circle the health, dental and/or vision care plan type and then coverage level you wish to elect for this plan year. *Remember your dental plan must be at the same coverage level or higher as your health coverage.*

	Health Care	**Dental Care**	**Vision Care**
Plan Type	Traditional Copay Plan (PPO)	*We only have one dental plan type. Please choose coverage level.*	Materials Only
	High Deductible Plan (HDHP)		Exam + Materials
	DECLINE COVERAGE	DECLINE COVERAGE	DECLINE COVERAGE
Coverage Level			
	Single	Single	Single
	Employee +1	Employee +1	Employee +1
	Family	Family	Family

Section 3: Please list your spouse and/or eligible dependents and their information below.
Please only list those you wish to cover.

Name	DOB	SSN	Gender	Full-Time Student?	Medicare Enrolled?	Other Coverage?	Relationship

Medicare/Other Coverage

If any of the above enrollees has Medicare, or other coverage please provide a copy of that Medicare or Health Care Coverage Card to our office.

Policy Holders Name________________________________ Policy #_______________________________

Carrier Name____________________________ Address____

Coverage Effective Date________________________ Coverage End Date___________________________

Did anyone over the age of 19 that you elected to enroll in our health care benefits have insurance coverage within the last 60 days? If yes, please list those names below and provide a certificate of credible coverage from that provider to our office.

Names: ____

Employee Acknowledgment

I understand the information I provided will be entered as is by Human Resources Personnel. I will be responsible for notifying Human Resources of any changes to the information provided so that accurate information is retained. If additional information was requested, I understand failure to submit those items may result in a delay of coverage. I understand if I wish to change my coverage status for health or dental care prior to open enrollment I must experience a qualifying event.

____

Employee Signature Date

To be completed by Human Resources

Date of Hire: ____________ Date Employee Eligible for Benefits: _______________

Form entered by: ______________________________ Date: ____________

Date Information forwarded to Auditor: _________________