



201 International Circle • 4th Floor • Hunt Valley, MD 21030 (410) 329-1800 • Fax (410) 329-1010

EMPLOYEE ELECTION FORM

Employer:		Business Phone:		Effective Date:		
Name of Employee (Last, First, Middle Initial)			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security #	
Home Address			City	State	Zip Code	
Home Phone #	E-Mail Address	Occupation		Employment Date	Hrs. Worked Per Week	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Name of Spouse		Spouse's Date of Birth	Date of Marriage		
	Is Your Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's Employer:		Spouse's Business Phone:		
COVERAGE APPLIED FOR:						
Type of Coverage		Medical Plan Choice		Network Option		
<input type="checkbox"/> Individual		<input type="checkbox"/> <<Option I>>:		<input type="checkbox"/> PMG Select		
<input type="checkbox"/> Employee & Child *		<input type="checkbox"/> <<Option II>>:		<input type="checkbox"/> Other:		
<input type="checkbox"/> Employee & Spouse *		<input type="checkbox"/> <<Option III>>:		<input type="checkbox"/> Other:		
<input type="checkbox"/> Family *		<input type="checkbox"/> <<Option IV>>:		<input type="checkbox"/> Other:		
<i>* Please Complete for Dependent Coverage. Attach additional sheet for more dependents.</i>						
	Dependent's Full Name (Last, First, Middle initial)	Sex	Date of Birth	Social Security #	Full-Time Student	Disabled
Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CONTRIBUTION:						
<input type="checkbox"/> I authorize my employer to deduct my contributions on a pre-tax basis from my paycheck each pay period.						
<input type="checkbox"/> I authorize my employer to deduct my contributions on an after-tax basis. By making this selection, I will not receive the tax savings.						

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Please fill out both sides of this form.

OTHER INSURANCE INFORMATION:**If you have other health insurance, failure to complete this section will cause significant delays in processing any claims submitted.**Is any person on the enrollment form covered by another health care plan, HMO, or Medicare? Yes NoIf Yes, will this coverage be continued? Yes No If No, Please provide the cancellation date ____/____/____

Name of Covered Person	Name of Other Insurance Carrier	Policy #	Effective Date	Termination Date	Medicare Part A	Medicare Part B
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

THIRD-PARTY LIABILITYHave you or any covered family member within the last 7 years been treated for injuries sustained due to the negligence of a third-party? (i.e. motor vehicle accident, slip and fall, dog bite, medical practice, product liability, assault, etc). Yes NoHave you or any covered family member filed an accident/injury report with an employer as a result of an on-the-job injury or illness whether or not you sought medical attention or lost time from work within the last 5 years or for which you are currently receiving compensation or treatment? Yes No**ELECTING COVERAGE**

As an eligible employee, I am applying for coverage under the terms of the plan(s) provided by my employer. I agree to the release of medical records or information that is needed to coordinate health care and benefits, to process claims and to monitor the care provided for me or my dependents. This information may come from, or go to, any appropriate government agency, health care provider, insurance carrier, or self-funded health plan. I understand that records and information will not be released by Fidelity for any other purposes, or to any other person, except as required by law or with my written consent or the written consent of my legal representative. A photocopy of this authorization is as valid as the original. My Fidelity Agent or Broker and I are entitled to receive a copy of this form

ENROLLING Employee Signature**Date****WAIVING COVERAGE****Please read carefully, by waiving coverage you may not be able to join until next enrollment period.**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself, your spouse or your dependents in this plan, provided you request enrollment within 31 days after your other coverage involuntarily ends. In addition, if you have a new dependent as a result of marriage, birth, guardianship, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your new dependents provided you request enrollment within 31 days after the marriage, birth, guardianship, adoption, or placement for adoption. I have read and understand this statement. I hereby certify that the medical benefits provided by my Employer have been explained to me, that I have been given an opportunity to apply for the health coverage and that I have voluntarily declined to participate in the benefit plan at this time.

Reason for waiver: **Not Interested** **Coverage Elsewhere****Carrier Name:****Employee Signature – PLEASE SIGN ONLY IF WAIVING COVERAGE****Date****Authorized Employer Signature****Date****FIDELITY INSURANCE COMPANY**

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