



**EMPLOYEE ELECTION FORM**

Please print clearly in **CAPITAL** letters

Please fill in the squares completely

New Subscriber

Member adding line of coverage

WAIVER (Signature Required)

COBRA

Retiree

Company Name: \_\_\_\_\_ KELLY Business Phone#: \_\_\_\_\_  
 Company ID#: \_\_\_\_\_

**1** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Title (Jr., III, etc.) \_\_\_\_\_  
 Street Address Number \_\_\_\_\_ Street Address Name \_\_\_\_\_ Apt# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Employee E-mail Address \_\_\_\_\_  
 Social Security# \_\_\_\_\_ Date of Birth (MM-DD-YY) \_\_\_\_\_ Gender  M  F Marital Status  S  M On your effective date, will you be actively at work on a full-time basis for this employer?  Y  N Hrs worked/wk \_\_\_\_\_  
 Home Phone# \_\_\_\_\_ Full-time Hire Date (MM-DD-YY) \_\_\_\_\_ Requested Effective Date (MM-DD-YY) \_\_\_\_\_  
 KELLY USE ONLY: **A**

2	Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	POS or HMO only:		Existing Patient (Y/N)
							Line 1: PCP Info: Physician Name	Line 2: OB/GYN Info: Physician #	
Emp									
Sp									
Chd									
Chd									
Chd									

\*If full time student, please submit proper form, or appropriate verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)

Participating Dentist / Provider Code / Dental Office #: \_\_\_\_\_

Existing Patient:  Y  N

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date (Part B) \_\_\_\_/\_\_\_\_/\_\_\_\_

3	HEALTH PLAN	DENTAL PLAN	VISION PLAN	Plan Name	Benefit Amount	Smoker?
Gp#:	_____	Gp#:	_____			
Carrier:	_____	Carrier:	_____	<input type="checkbox"/> Life AD&D	\$ _____	<input type="checkbox"/> Y
Plan:	_____	Plan:	_____	<input type="checkbox"/> Vol. Life	\$ _____	<input type="checkbox"/> Y
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Life AD&D	<input type="checkbox"/> Vol. AD&D	\$ _____	<input type="checkbox"/> Y
<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. Sp. Life	\$ _____	<input type="checkbox"/> Y
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Vol. AD&D	<input type="checkbox"/> Vol. Dep. Life	\$ _____	<input type="checkbox"/> Y
<input type="checkbox"/> Family	<input type="checkbox"/> Family	<input type="checkbox"/> Family	<input type="checkbox"/> Vol. Sp. Life	<input type="checkbox"/> STD	\$ _____ /wk	<input type="checkbox"/> Y
<input type="checkbox"/> Over 65 & Working FT	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Vol. Dep. Life	<input type="checkbox"/> Vol. STD	\$ _____ /wk	<input type="checkbox"/> Y
<input type="checkbox"/> Over 65 & Retired			<input type="checkbox"/> STD	<input type="checkbox"/> LTD	\$ _____ /mo	
<input type="checkbox"/> Waive Coverage			<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	\$ _____	
			<input type="checkbox"/> LTD	<input type="checkbox"/> Suppl. Life/AD&D	\$ _____	
			<input type="checkbox"/> Suppl. Life/AD&D			

**4** Employee Occupation \_\_\_\_\_ Class \_\_\_\_\_ Annual Salary \_\_\_\_\_  
 Primary Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
 Secondary Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

**5 OTHER INSURANCE INFORMATION**  
 Will you or your dependents continue health coverage with another insurer?  Yes  No  
 Other Health Insurer Name \_\_\_\_\_  
 Who is covered?  Self  Spouse  All Policy # \_\_\_\_\_  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Term Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**CERTIFICATION:** I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that I am the spouse, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form.

**THIS IS NOT AN APPLICATION FOR INSURANCE**

**6** EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 EMPLOYER SIGNATURE / VERIFICATION \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_