

# Universal Enrollment/Change Form

<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Enrollment <input type="checkbox"/> Late Enrollment (Statement of Health Required for Late Entrants)	<input type="checkbox"/> BENEFICIARY CHANGE <input type="checkbox"/> COVERAGE CHANGE REASON:	<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> DROP DEPENDENT REASON:	<input type="checkbox"/> COBRA <input type="checkbox"/> OTHER SPECIFY:
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**Employer Information:**

Employer Name <b>Pantheos</b>			
Address		City	State      Zip
Group Number: <b>M001167</b>	Division:	Class:	Date of Hire:      Coverage Effective Date:

**Employee Information:**

Last Name		First Name		M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Social Security Number		Date of Birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Number of Hours per Week: _____
Residence Mailing Address (Number, Street, Apartment)			City		State      Zip
Home Telephone (      )			Salary: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual    Amount: \$		Occupation/Job Title:

**Please complete the area below for any Dependent coverage:** (Dependent information must be completed if choosing ANY coverage for dependents.)

FIRST NAME	LAST NAME	RELATIONSHIP DAUGHTER (D) OR SON (S)	SEX		DATE OF BIRTH (MM-DD-YY)	SOCIAL SECURITY NUMBER	Are you electing coverage for this dependent?
			M	F			
		Spouse					

**Voluntary Disability Elections (Please choose one option for each coverage.)**

<b>Voluntary Short Term Disability – Lincoln Financial</b> <input type="checkbox"/> I elect Voluntary Short Term Disability Amount: \$ _____ (\$100 Minimum) \$50 increments to a \$1000 weekly maximum This amount may not exceed 60% of your weekly earnings. <input type="checkbox"/> I decline Short Term Disability	<b>Voluntary Long Term Disability – Lincoln Financial</b> <input type="checkbox"/> I elect Voluntary Long Term Amount: \$ _____ (\$500 Minimum) \$100 increments to a \$5,000 monthly maximum This amount may not exceed 60% of your monthly earnings. <input type="checkbox"/> I decline Long Term Disability
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**Voluntary Life (Please choose one option below.)**

<b>Voluntary Life - Lincoln Financial</b> <input type="checkbox"/> I elect Employee Voluntary Life Amount: \$ _____ (Increments of 10,000 to a 300,000 Maximum: Amount may not exceed 5Xs Annual Salary) <input type="checkbox"/> I elect Voluntary Life for my Spouse * Amount: \$ _____ (Increments of 5,000 to a 150,000 Maximum: Amount may not exceed 50% of the EE Election) <input type="checkbox"/> I elect Voluntary Life for my Child(ren) * Amount: \$ _____ (10,000 age 6 mos to 19/25 if a full time unmarried student: 14 days to 6 mos, \$250 benefit: No benefit 0 to 14 Days) *Employees must elect Voluntary Life to have Spouse and/or Child(ren) coverage <input type="checkbox"/> I decline all Voluntary Life
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**Beneficiary Information:** (For Life) 1=Primary 2=Contingent

Name	Address	Relationship	Benefit Percent
1.			
2.			

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Signature Section:**

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in Spouse & Child(ren) status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

**X**

Employee Signature

Date