Universal Enrollment/Change Form

☐ Annual Enrollment ☐ New Enrollment ☐ Late Enrollment (Statement of Health Required for Late Entrants)	❑ BENEFICIARY CHANGE ❑ COVERAGE CHANGE REASON:	❑ ADD DEPENDENT ❑ DROP DEPENDENT REASON:	❑ COBRA ❑ OTHER SPECIFY:

Employer Information:

Employer Name ***Pantheos***					
Address			City	State	Zip
Group Number: **M001167**	Division:	Class:	Date of Hire:	Coverage Effective Date:	

Employee Information:

Last Name	First Name		M.I.	Marital Status ❑ Single ❑ Divorced ❑ Married ❑ Widowed
Social Security Number	Date of Birth	Gender ❑ Male ❑ Female	Number of Hours per Week: _____	
Residence Mailing Address (Number, Street, Apartment)	City		State	Zip
Home Telephone ( )	Salary: ❑ Hourly ❑ Weekly ❑ Monthly ❑ 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 M	SEX F	DATE OF BIRTH (MM-DD-YY)	SOCIAL SECURITY NUMBER	Are you electing coverage for this dependent?
		Spouse					

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

Voluntary Short Term Disability – Lincoln Financial
❑ 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.
❑ I decline Short Term Disability

Voluntary Long Term Disability – Lincoln Financial
❑ 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.
❑ I decline Long Term Disability

Voluntary Life (Please choose one option below.)

Voluntary Life - Lincoln Financial
❑ I elect Employee Voluntary Life Amount: $_____(Increments of 10,000 to a 300,000 Maximum: Amount may not exceed 5Xs Annual Salary)
❑ I elect Voluntary Life for my Spouse * Amount: $_____(Increments of 5,000to a 150,000 Maximum: Amount may not exceed 50% of the EE Election)
❑ 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

❑ I decline all Voluntary Life

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