2016 BENEFIT ENROLLMENT FORM

Please complete this form in its entirety. Provide a checkmark next to your elected benefit, or next to "decline" if you are not electing the benefit. Please return this form by the due date, even if you are declining coverage.

Client Name: Greater Opportunities of the Permian Basin, Inc.

For HR Completion
Effective Date: _____

Employee First Name: _____ **Last Name:** _____

SSN: _____ Date of Hire: _____ Date of Birth: _____

Occupation: _____ Marital Status: _____ Gender: □ Male □ Female

Phone: _____ Email Address: _____ Hours worked per week: _____

Address: _____ City: _____ ST: ____ ZIP: _____

Medical

__ I elect medical coverage
__ I decline medical coverage
If declining, provide reason below:

Coverage Level *(Choose 1)*
__ Employee
__ Employee + Spouse
__ Employee + Child(ren)
__ Family

Plan Design Selected *(Choose 1)*
___ Healthy100 3500
___ HealthyConsumer 6500

Reason for decline:
□ Spouse's Employer's Plan □ Individual Plan □ Medicare □ Medicaid □ COBRA from Prior Employer □ VA Eligibility
□ I (we) have no other coverage at this time □ Other: _____

Additional Coverage: Do you or any family member have other group health coverage that will continue in addition to this coverage?
□ Yes* □ No Coverage: □ Family □ Single
*If yes and family member will be covered on the Lifestyle Plan, you must complete a Coordination of Benefits questionnaire to prevent delay of claims processing.

Note: Major medical plan participants may receive up to a $500 deductible credit for participating in the Lifestyle Healthy Rewards Wellness Program.

Dental

__ I elect dental coverage
__ I decline dental coverage

Coverage Level *(Choose 1)*
__ Employee
__ Employee + Spouse
__ Employee + Child(ren)
__ Family

Plan Design Selected *(Choose 1)*
___ n/a

Vision

__ I elect vision coverage
__ I decline vision coverage

Coverage Level *(Choose 1)*
__ Employee
__ Employee + Spouse
__ Employee + Child(ren)
__ Family

Plan Design Selected *(Choose 1)*
___ n/a

Enrolling Dependent Information:

Dependent First Name, Last Name	**SSN**	**Relationship** (Spouse, Daughter or Son)	**Date of Birth** (MM/DD/YYYY)	**Dental** (Y / N)	**Vision** (Y / N)

Authorization: *As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.*

Signature: _____ **Date:** _____