HealthCare SOLUTIONS GROUP

MESA Quality Focused, Service Driven.

MEDICAL/DENTAL/VISION ENROLLMENT & CHANGE FORM

ALL NEW EMPLOYEES MUST COMPLETE THIS FORM TO RECEIVE MESA PAID LIFE INSURANCE, SHORT-TERM, AND LONG-TERM DISABILITY BENFITS

☐ This is a new enrollment ☐ This is a change to my current coverage

EMPLOYEE INFORMATION

Last Name	First Name	M.I.	Social Security Number	Date of Birth

Mailing Address	City	State	Zip	Email Address

Home Phone	Cell Phone / Other	Gender	Marital Status
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed ☐ Divorced

MESA Hire Date	Temporary Hire Date (if applicable)	Effective Date of Coverage

COVERAGE INFORMATION

Coverage Tier for Medical/Dental/Vision	Current Salary
☐ Employee Only ☐ Employee & Child(ren) ☐ Family ☐ No Coverage	$ ☐ Hourly ☐ Annually

BENEFICIARY INFORMATION

All proceeds will go in equal shares to the primary beneficiary(s). If the primary beneficiary(s) is not living, all proceeds will go in equal shares to the secondary beneficiary(s).

Name (Last, First, M.I.)	Relationship	Social Security Number	Type
			Primary
			☐ Primary ☐ Secondary
			☐ Primary ☐ Secondary

DEPENDENT INFORMATION

Name (Last, First, M.I.)	Relationship	Social Security Number	Date of Birth	Gender
	☐ Spouse ☐ Child			☐ Male ☐ Female
	Child			☐ Male ☐ Female
	Child			☐ Male ☐ Female
	Child			☐ Male ☐ Female
	Child			☐ Male ☐ Female
Is any applicant disabled or handicapped?	☐ Yes (provide documentation) ☐ No			

CHANGE INFORMATION

1. Add Dependents (List new dependents above) — Effective Date
   ☐ Marriage ☐ Birth/Adoption ☐ Other (specify): _____
2. Remove Dependents Name(s): _____
   ☐ Divorce/Deceased ☐ Ineligible ☐ Other (specify): _____
3. ☐ Change Coverage Tier to that shown above
4. ☐ Change name to that shown above Former Name: _____
   Does this name change affect other covered dependents? ☐ Yes ☐ No (specify): _____
5. ☐ Change Beneficiary(s) to that shown above
6. ☐ Other (specify):

ACCEPTANCE OF COVERAGE

I am enrolling for coverage under MESA's health benefit plan.

Signature **Date**

DECLINING COVERAGE (for yourself and/or any eligible dependent)

If you have refused employee or dependent coverage, is it because you or your dependents have other coverage? ☐ Yes ☐ No

If yes, who is covered? _____ Name of Carrier: _____

Type of coverage: ☐ Medical ☐ Dental

If you are declining enrollment for yourself or any dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. To qualify for the special enrollment period, the employee (or dependent) must have lost the other group health plan coverage because either COBRA is now exhausted or non-COBRA coverage terminated due to loss of eligibility for coverage (including due to legal separation, divorce, death, termination of employment, or reduction of the hours) or because employer contributions for the coverage were terminated, I understand the above statement and forfeit my right to become eligible unless I qualify under the above conditions.

I waive health coverage for myself and/or dependents, if any.

Signature **Date**