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Benefit Selection Form

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Social Security Number		Last Name		First Name		M.I.	Birth Date		Gender (Check One) Male <input type="checkbox"/> Female <input type="checkbox"/>	
Home Address			New Address? Yes <input type="checkbox"/> No <input type="checkbox"/>	City		State	ZIP		Marital Status (Check One) Single <input type="checkbox"/> Married/Domestic <input type="checkbox"/> Divorced <input type="checkbox"/>	
Home E-mail		Home FAX		Pager		Mobile Phone		Work Phone		Work FAX

I have reviewed the dental plan options and elect coverage under the plan initialed below. I understand that benefits will only be available from the plan in which I have enrolled.

Dental Plans	Initial One	DENTAL PLANS			PLAN OFFICE USE ONLY		EligID _____	
		DELTA DENTAL PPO					Effective Date: _____	
	PREPAID DENTAL ENROLLEES ONLY: If you choose DeltaCare, indicate the number of the Dental Office you and your dependents will use.							
		DeltaCare USA (Formerly PMI)	Dental Office Number		Dentist's Name		Dental Plan: # _____ DD/PPO DC/USA	

PLAN OFFICE USE ONLY		
Effective Date: _____		
ACT	RET/SUR	COBRA
Dental Plan: # _____ DD/PPO DC/USA		

I have reviewed the medical plan options and elect coverage under the plan initialed below. I understand that benefits will only be available from the plan in which I have enrolled.

Medical Plans	Initial One	COMPREHENSIVE MEDICAL / HOSPITAL PLAN				PLAN OFFICE USE ONLY		
		MPIHP / BLUE SHIELD OF CALIFORNIA (Nationwide)						
		HEALTH MAINTENANCE ORGANIZATION		Previous Member of This Plan				
		KAISER PERMANENTE (California Only)	YES	NO	LAST DATE COVERED	PREVIOUS GROUP		
	Plans listed below require that eligible members must receive all medical care through the Medical Group or Independent Practice Association (IPA) selected, and must live within the service area.							
		HEALTH NET (California Only)				Name of Medical Group or IPA Selected		Facility Number
		OXFORD (NY, NJ, CT Area Only)				Name of Medical Group or IPA Selected		Facility Number

PLAN OFFICE USE ONLY			
Effective Date: _____			
K	HNET	OX	BS/PPO
Medical Plan: # _____			

LIST ALL ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE PLANS SELECTED ABOVE

If you choose HEALTH NET or OXFORD AND AN Independent Practice Association (IPA), use your Provider Directory to choose a Primary Care Physician for you and your dependents. You may choose a different physician for each member of your family. If you fail to list a Primary Physician, HEALTH NET or OXFORD will assign one to you.

Employee & Family Information		Incorrect Information may result in non-payment of claims.			Status	HEALTH NET or OXFORD PRIMARY CARE PHYSICIAN	
Last Name (Self)	First Name	Birth Date M/D/Yr	Gender (Check One)	Social Security Number (Required)	See Codes Below	Name of Primary Care Physician <i>Only</i> if you selected an IPA above	Physician / Facility Number

Status Codes: SP - Spouse DP - Domestic Partner CH - Biological Child FC - Foster Child AD - Adopted Child LG - Legal Guardianship SC - Step Child ST - Student (Age 19 - 23) HN - Disabled (Over Age 18)
 Copies of birth certificates, marriage certificates, and/or other forms of documentation (dependent applications, divorce/custody documents) are required to enroll dependents.

Do you or any family members have other group medical insurance? **Yes** **No**

If yes, please provide: _____ Name(s) of the Insured(s)
 If Yes, please provide: _____ Name, Policy Number and Effective date of other Group Medical Insurance

I understand this election will remain in effect until I make another election during an open enrollment period. I want to enroll myself and those eligible family members of my family, listed above, for participation in the plan elected. I also understand that it is my responsibility to report any change of address and any change in the eligibility status of my dependents. I hereby authorize the Health Plan, any insurance company, organization, employer, hospital, physician, or surgeon to release any information required or requested to process any claim under the plan selected. **I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

EMPLOYEE SIGNATURE _____ DATE SIGNED _____