2014-2015

JACAM Enrollment Form

Effective Date: ______________

☐ Qualifying event

Reason:

Name: ____________ Phone Number: ____________
Address: ____________ Email Address: ____________
City: ____________ State: ____ Zip: ____________ Date of Birth: ____________
SSN: ____________ Marital Status: ☐ Single ☐ Married ☐ Domestic Partner
Date of Hire: ____________ Annual Salary: ____________
Gender: ☐ Male ☐ Female Job Title: ____________
Employee Monthly Rates Shown Below: Division: ____________

Coverage Type		Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Waive
Medical: CoreSource	Tradtional	☐ $114.45	☐ $245.67	☐ $232.30	☐ $364.00	☐
	High Deductible	☐ $95.47	☐ $158.10	☐ $176.90	☐ $258.99	
Dental: Delta Dental of KS		☐ $23.67	☐ $50.89	☐ $46.96	☐ $73.59	☐
Vision: VSP		☐ 9.77 ee only	☐ $14.16 ee+1	☐ $25.39 ee 2+		☐
Basic Life/AD&D: Assurant		☒				
Voluntary Life AD&D		☐ Coverage Cost	☐ Coverage Cost	☐ Coverage Cost		☐
Short Term Disability		☐ Coverage Cost				☐
Long Term Disability		☐ Coverage Cost				☐
Accident		☐ $11.28 Low ☐ $16.92 High	☐ $16.92 Low ☐ $25.38 High	☐ $22.56 Low ☐ $33.84 High	☐ $28.20 Low ☐ $42.30 High	☐
Critical Ilness		☐ Coverage Cost	☐ Coverage Cost	☐ Coverage Cost	☐ Coverage Cost	☐
Cancer		☐ $15.62 Low ☐ $24.36 High	☐ $24.90 Low ☐ $38.06 High	☐ $21.46 Low ☐ $34.10 High	☐ $30.72 Low ☐ $47.78 High	☐
Legal Sheild		☐ $25.90 Combo	☐ $15.95 Legal	☐ $12.95 Theft	☐ $1.00 Dep.	☐
Flexible Spending Account	Medical	☐ Per Pay Period:		Annual Election:		☐
	Dependent Care	☐ Per Pay Period:		Annual Election:		☐

Coordination of Benefits

Will you &/or any enrolling dependents have other health coverage in addition to this plan?

If yes, other insurance company name: ____________
Group #: ________ ID #: ____________
Name of those that will be covered on the JACAM plan & other plan: ____________

Primary Beneficiary(ies) (Last, First, MI)	Address	SSN	Birthdate	Relationship	%

Secondary Beneficiary(ies) (Last, First, MI)	Address	SSN	Birthdate	Relationship	%

(Complete this portion if you are enrolling a spouse and or dependents on your plan)

Dependent Coverage:

Spouse Name: ____________ Gender: ☐ Male ☐ Female SSN: ________ DOB: ________
Child Name: ____________ Gender: ☐ Male ☐ Female SSN: ________ DOB: ________
Child Name: ____________ Gender: ☐ Male ☐ Female SSN: ________ DOB: ________
Child Name: ____________ Gender: ☐ Male ☐ Female SSN: ________ DOB: ________
Child Name: ____________ Gender: ☐ Male ☐ Female SSN: ________ DOB: ________
Child Name: ____________ Gender: ☐ Male ☐ Female SSN: ________ DOB: ________

Ee Signature: ____________ **Date:** ________