



## Benefits Enrollment Form

Location: School Food Services - \_\_\_\_\_

| Please complete the following information |           |               |                |                              |
|---|-----------|---------------|----------------|------------------------------|
| Social Security No.                       | Last Name | First         | Middle         | Date of Birth                |
| Home Address                              |           | Home Phone    |                | Gender                       |
| City                                      | State     | ZIP Code      | Business Phone | DOL Division #<br><b>169</b> |
| Effective Date                            | Hire Date | Email Address |                |                              |

| Please list all of your eligible dependents that are to be covered |    |      |   |            |
|--|----|------|---|------------|
| First  | MI | Last | Sex   | Birth Date |
| Spouse:  |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |
| Child:   |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |
| Child:   |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |
| Child:   |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |
| Child:   |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |
| Child:   |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |
| Child:   |    |      | M <input type="checkbox"/> F <input type="checkbox"/> | / /        |

| <b>DENTAL</b> | Base (Medical)<br>GR# CD7356 | Buy-Up (Medical)<br>GR# CD7744 | Buy-Up (No Medical)<br>GR# CD7746 |
|---------------|------------------------------|--------------------------------|-----------------------------------|
| EE Only       | <input type="checkbox"/>     | <input type="checkbox"/>       | <input type="checkbox"/>          |
| EE+ Spouse    | N/A                          | <input type="checkbox"/>       | <input type="checkbox"/>          |
| EE+ Children  | N/A                          | <input type="checkbox"/>       | <input type="checkbox"/>          |
| Family        | N/A                          | <input type="checkbox"/>       | <input type="checkbox"/>          |

| <b>VISION</b> | Base (Medical)<br>GR# VS7743 | Base (No Medical)<br>GR# VS7745 | Buy-Up (Medical)<br>GR# VS7744 | Buy-Up (No Medical)<br>GR# VS7746 |
|---------------|------------------------------|---------------------------------|--------------------------------|-----------------------------------|
| EE Only       | <input type="checkbox"/>     | <input type="checkbox"/>        | <input type="checkbox"/>       | <input type="checkbox"/>          |
| Family        | <input type="checkbox"/>     | <input type="checkbox"/>        | <input type="checkbox"/>       | <input type="checkbox"/>          |

I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_