Carnegie Institution of Washington

NEW HIRE BENEFIT ENROLLMENT FORM

EFFECTIVE DATE:_____

Last Name	First Name	MI	Date of Birth:

Street Address	Email Address:	Social Security Number:

City	State	Zip	Gender: Male ☐ Female ☐	Hire Date:

Home Telephone	Mobile/Cell Phone	Marital Status ☐Single ☐Married ☐Divorced ☐ Widowed	New Hire ☐ Rehire ☐ If Rehire, Last date worked:

Job Title	Annual Salary/Hourly Wage	Hours Worked/Week

MEDICAL PLAN: AETNA

☐ **Platinum Plus - ($250 Ded Plan)**
☐ **Platinum - ($500 Ded Plan)**
☐ **Gold - (HSA- High Ded Health Plan)**

☐ **Employee Only**
☐ **Employee + 1**
☐ **Family**
☐ **Waive Coverage***

DENTAL: DELTA DENTAL INSURANCE COMPANY

☐ **Delta Dental HMO**
~Select Primary Care Dentist below
☐ **Delta Dental PPO Plus Premier – DC04563**

☐ **Employee Only**
☐ **Employee + 1**
☐ **Family**
☐ **Waive Coverage***

VISION: EYEMED

☐ **Employee Only**
☐ **Employee + 1**
☐ **Family**
☐ **Waive Coverage***

SPENDING ACCOUNTS: BENEFIT STRATEGIES FSA / DFSA / HSA:

☐ **FSA -** Not w/ HSA plan
$_____max $2,700

☐ **Dependent Care FSA**
$_____max $5,000

☐ **HSA**
ONLY w/ GOLD-HSA Election Plan
$_____ (See Benefit Guide for limits)

☐ **Limited FSA**
ONLY w/ GOLD-HSA Election Plan
$_____max $2,700

Delta Dental HMO Primary Care Dentist
(*Required for Delta Dental HMO enrollees*)

Name:

Delta Dental HMO Primary Dental Office ID No.
(*required for all Delta Dental HMO enrollees*)

Office ID:

***Waiver of Coverage: I certify that group insurance coverage has been offered to me and I choose to waive coverage due to**:
☐Spousal Coverage ☐ Individual Coverage ☐ Military Coverage ☐ COBRA ☐ Medicare as primary under TEFRA ☐ No Coverage

**Group Coverage: For Coordination of Benefits, Prior/Other Coverage Information Must Be Completed:
Do you or your dependents have other/prior Health coverage with another insurer? Yes ☐ No ☐
If yes, please complete the following: Effective Date of Coverage: _____

Carrier Name and Address: _____ Group Number: _____

Life Insurance Beneficiary
(If more than one beneficiary, list in Special Remarks section)

Full Name (please print): _____ Relationship: _____

If electing Medical/Dental or Vision coverage for Dependents, please fill out the information below. (Attach sheet to list additional children)

List individuals for whom you are adding coverage *(Explain difference in last names in Special Remarks)* : Name (First, Middle Initial, Last)	Relation	MED	DENT	EYE	Social Security Number (If dependent has no SSN, write "None")	Birth Date	Gender	**Student (Y/N)**
Primary Enrollee:	**SELF**							

Special Remarks:

OTHER / PRIOR HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare.

**GROUP COVERAGE: FOR COORDINATION OF BENEFITS, OTHER/PRIOR COVERAGE INFORMATION MUST BE COMPLETED.

Do you or your dependents have Prior Insurance Plan and/or Other Medical Coverage? ☐ No ☐ Yes

If Yes to Prior Insurance Plan and/or Other Medical Coverage, provide effective dates, name, address & policy/group number of insurance carrier, or other source and your Member Identification Number:

_____

_____

_____

Will this coverage be continued? ☐ Yes ☐ No *If No*: Termination Date: _____

Are you or your spouse covered by Medicare? **Employee**: ☐ Yes ☐ No **Spouse**: ☐ Yes ☐ No

If yes, please provide the following:

Employee: Effective Date (Part A) __ /__ /__ Effective Date (Part B) __ /__ /__ Medicare #: _____

Spouse: Effective Date (Part A) __ /__ /__ Effective Date (Part B) __ /__ /__ Medicare #: _____

Name of spouse or dependent(s) covered (if applicable): _____

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief:

_____ _____

Employee Signature Date

EMPLOYER GROUP INFORMATION (To be completed by Employer):

GROUP NUMBERS:

Aetna _____

Delta Dental _____

EyeMed _____