[](http://www.piercegroupbenefits.com/) **Chowan County Government – Enrollment Form**

**New Enrollee/ Open Enrollment Change Retiree/ Terminate**

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| **General Information** | | | | | | | | | | | | | | |
| **1) Name of Account**  **Chowan County Government** | | | | | | | | | | | | | | |
| **2) Employee Name** Last First MI | | | | | | | | | | | | | | |
| **3) Social Security #** | | | **4) Annual Salary** | | | | **5) DOB** | | | | **6) Gender**  **M F** | | | |
| **7) Mailing Address** Street City State Zip | | | | | | | | | | | **8) Home Phone** | | | |
| **9) If Change of Status, Please specify:**  Add Terminate Change Correction  Reason: Date: | | | | | | **10) Hire Date** | | **11) Hrs. Wkd/Wk** | | | **12) Marital Status**  Married Divorced Single | | | |
|  | | | | | | | | | | | | | | |
| **Dependents** (Complete for all Dependent Coverage)  **\**Please check the type of coverage desired for each dependent listed***  *Name Relationship M/F DOB Social Security # Health Dental Vision Dep Life* | | | | | | | | | | | | | | |
| 1 | |  | |  |  | |  | |  | | |  |  |  |
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| 4 | |  | |  |  | |  | |  | | |  |  |  |
| 5 | |  | |  |  | |  | |  | | |  |  |  |
| 6 | |  | |  |  | |  | |  | | |  |  |  |
| 7 | |  | |  |  | |  | |  | | |  |  |  |
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| **HEALTH** | Company Name: **Aetna** | | | | | | | | | Policy  Number 837929 | | | | |
| I wish to elect coverage for (circle one): Employee Only (Self) Employee + Spouse  Employee + Child(ren) Employee + Family | | | | | | | | | | | | | | |
| Was the **employee** enrolled in a prior health plan? NO YES List # of months: | | | | | | | | | | | | | | |
| Were the **dependents** enrolled in a prior health plan? NO YES List # of months: | | | | | | | | | | | | | | |
| Previous Carrier Name: Policy Number: | | | | | | | | | | | | | | |
| Effective Date: Termination Date: | | | | | | | | | | | | | | |
| I wish to decline/waive coverage:  Reason: | | | | | | | | | | | | | | |
| **HEALTH EFFECTIVE DATE:** | | | | | **HEALTH TERMINATION DATE:** | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **DENTAL** | Company Name: **MetLife** | | | | | | | | | Policy  Number 5918326 | | | | |
| I wish to elect coverage for: Employee Only (Self) Employee + Spouse  Employee + Child(ren) Employee + Family | | | | | | | | | | | | | | |
| Was the **employee** enrolled in a prior dental plan? NO YES List # of months: | | | | | | | | | | | | | | |
| Were the **dependents** enrolled in a prior dental plan? NO YES List # of months: | | | | | | | | | | | | | | |
| I wish to decline/waive coverage:  Reason: | | | | | | | | | | | | | | |
| **DENTAL EFFECTIVE DATE:** | | | | | **DENTAL TERMINATION DATE:** | | | | | | | | | |

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| **VISION** | Company Name: **Superior Vision** | | Policy  Number 031190 |
| I wish to elect coverage for (circle one): Employee Only (Self) Employee + Spouse  Employee + Child(ren) Employee + Family | | | |
| I wish to decline/waive coverage:  Reason: | | | |
| **VISION EFFECTIVE DATE:** | | **VISION TERMINATION DATE:** | |

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| **TERM LIFE** | Company Name: **MetLife** | | | | | | Policy  Number 5918326 | | |
|  |
| Add  Effective Date: | | Remove Termination Date: | | | Change Effective Date: | | | | |
|  | |  | | |  | | | | |
| OPTIONAL **BASIC** VOLUNTARY DEPENDENT LIFE (EMPLOYEE PAID): NO YES (LIST DEPENDENTS ON PG 1) | | | | | | | | | |
| **Beneficiary Designation** Dependent coverage Beneficiary is always the employee  *Full Name (Last, First, MI) Relationship Social Security Number DOB Primary Secondary %* | | | | | | | | | |
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| OPTIONAL **GROUP** TERM LIFE (EMPLOYEE PAID): NO YES  **Employee Volume: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Semi-monthly Premium (see rate chart): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Spouse Volume (not to exceed 50% of Employee’s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Semi-monthly Premium (see rate chart): $\_\_\_\_\_\_\_\_\_\_\_**  **Child: \_\_\_\_\_ $1,000 (.15 per pay period) \_\_\_ $2,000 (.29 per pay), $4,000 (.58 per pay) \_\_\_\_$5,000 (.73 per pay) \_\_\_\_$10,000 (1.46 per pay)** | | | | | | | | | |
| **Beneficiary Designation Dependent coverage Beneficiary is always the employee**  **Full Name (Last, First, MI) Relationship Social Security Number DOB Primary Secondary %** | | | | | | | | | |
| 1 | |  |  |  | |  | |  |  |
| 2 | |  |  |  | |  | |  |  |
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| **Employee Signature: Date Signed:** | | | | | | | | | |

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| **Certification &** I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to  **Authorization** all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provide me and the certificate issued me.  I understand that the effective date of insurance for myself or for any of my dependents is subject to being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the above companies give their written consent.  I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the insurance companies do not receive notice of the Enrollment/Change Request within a reasonable time following the event, my and my dependents' eligibility may be affected.  I request my employer to arrange for the issuance of the coverage listed above for which I am or may become eligible and authorize deductions of the required contributions from my earnings. |
| **Employee Signature: Date Signed:** |