GIS | Benefits

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.	EE ID:	Group Policy #:	Billing Division or Location:

Employee Information (Complete for ALL Enrollments)					
Employer Name/Company Name **Ozaukee County**		County	Employer ZIP	State	
Employee First Name / Middle Initial / Last Name		Social Security Number		Date of Birth	
Street Address		City		State	Zip
Gender:	Marital Status:	Home Phone	Work Phone	Email Address:	

Employee Work Information (Complete for ALL Enrollments)				
Average Work Week Hours:	Occupation:	Earnings:	Full-Time Employment Date:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Type of Coverage	**Selecting yes authorizes my employer to payroll deduct premium(s)**	**Amount of Coverage**	**Semi-Monthly Premium**
Voluntary Employee Life & AD&D Provided By: MetLife	☐ **Yes** ☐ **No*** **Guarantee Issue: $150,000**	☐ $20,000 ☐ $40,000 ☐ $60,000 ☐ $80,000 ☐ $100,000 ☐ $150,000 ☐ OTHER $ _____	
Voluntary Spouse Life & AD&D Provided By: MetLife Spouse amount **cannot** exceed 50% of the employees elected amount.	☐ **Yes** ☐ **No*** **Guarantee Issue: $30,000**	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ OTHER $ _____	
Voluntary Child Benefit Provided By: MetLife	☐ **Yes** ☐ **No***	☐ $10,000 ☐ Other_____	$1.46
Short Term Disability Provided By: MetLife	☐ **Yes** ☐ **No***	**Weekly Benefit Amount:** ☐ OTHER $ _____	

*By selecting no, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense

-- Actual deductions may vary slightly from above illustration due to rounding –

Beneficiary Information (Complete for Life or AD&D Enrollments)					
Last Name	First Name	MI	Relationship of Beneficiary	Social Security Number	Date of Birth
Street Address			City	State	Zip
Last Name	First Name	MI	Relationship of Beneficiary	Social Security Number	Date of Birth
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Dependent and Other Insurance Information (Complete for Dependent Coverage)					
	Last Name	**First Name**	**Gender**	**Date of Birth**	**Social Security #**
Spouse:					
Child:					
Child:					
Child:					

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature Section:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name: _____

Employee Signature: _____ Date: _____

Boon-Chapman Benefit Administrators, Inc. is a third party administrator that provides premium billing services for the insurance companies offering coverage under this Form.