HEALTHCARE ENROLLMENT/CHANGE FORM
Full-Time Employees

1: EMPLOYEE INFORMATION – PLEASE COMPLETE THE ENTIRE SECTION

Name (Last, First, Middle):____ FIT ID#: @________________________

Street Address:____

City:____ State:__________ Zip Code: ______________________

Date of Birth:_____________________________ Gender: ________ Telephone Number: ______________________________

2: HEALTH CARE PLAN

Initial Enrollment

Change: Requested Date of Change: _________________________

Select applicable coverage:

Aetna Choice POS II Plan

Waive FIT's Health Care Plan Coverage – I and my eligible dependents (if applicable) are covered by another health care plan or by FIT's health care plan under another employee. If covered under another FIT employee, please provide employee's name:

____

Level of Coverage & Employee Premium Cost Per Pay Period (*select one*)

Employee only ($40) Employee + 1 dependent ($70) Employee + 2 or more dependents ($90)

*I understand that **this plan does not offer prescription drug coverage** which is provided by the UCE of FIT Welfare Trust Fund (among other benefits). I must contact Anne Golden, UCE of FIT Welfare Trust Fund Manager, directly for information about this coverage and to enroll, add or drop a dependent(s) or otherwise change an existing election.*

3: ENROLLMENT & CHANGES

List all dependents you are adding, changing, or removing under your coverage. Attach a sheet to list additional dependent(s).

(**A**)dd (**C**)hange (**R**)emove	Last Name, First Name, M.I.	Gender	Relationship to Employee	Birthdate MM DD YYY	Social Security Number

4: EMPLOYEE AUTHORIZATION: I certify that all information that I have supplied is true to the best of my knowledge. Once elections I have made on this form become effective, they will remain in effect unless I make a change due to a qualified change in family status as defined by law or if I make a change during a subsequent annual open enrollment period. If I waive coverage for myself or my dependent(s), by signing this form, I am acknowledging that I or my dependent(s) have other health care coverage outside FIT (or am/are covered under FIT's health care plan by another employee). I understand that I have 31 days from the date of a qualified change in family status to notify a FIT Benefit Representative of the change in order to modify my election as allowable. The Plan documents will determine the rights and responsibilities of the member(s) and will govern in the event they conflict with any benefits comparison, summary, or other description of the plan. *I understand that the applicable pre-tax contribution will be taken from my semi-monthly paychecks.*

Signature____ Date______________________________

FOR EMPLOYER USE ONLY:

Hire Date: Effective Date: Waiver Payment: