



# Good Fit Medical, Dental, Basic Life & AD&D Application

PLAN GROUP NUMBER	Active Employees	Retirees
Alliant Select Plan	#50616	#50617
Alliant Plus Plan	#55209	#57183
Group Health Essentials Plan	#6171500	#6171600
Washington Dental Service Plan	#287	#287
Willamette Dental Plan	#Z861	#Z861

## Section A. Indicate the purpose of this application and supply basic employee information (please print):

Purpose of Application:	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Information Change	<input type="checkbox"/> Add a Dependent	Notes:	HR Use ONLY: Δ Medical Δ Dental		
	<input type="checkbox"/> New Employee	<input type="checkbox"/> Terminate Employee & Dependent	<input type="checkbox"/> Remove a Dependent				
Subscriber's Last Name:	First:	MI:	Marital Status:	Date Married:	Home Phone:	Date of Hire:	
			<input type="checkbox"/> Married <input type="checkbox"/> Single				
Home Mailing Address:	City:	State:	Zip:	Department:	Work Phone:	Hours worked/week/FTE status:	
						<input type="checkbox"/> Active <i>Or</i> <input type="checkbox"/> Retired	

## Section B. Use this section to enroll yourself and your dependents:

You may elect to enroll yourself only or to include some or all of your family members. The Medical and Dental plans are independent, so you may elect to enroll different family members on medical than on dental, BUT all family members enrolling must choose the same medical or dental plan.

Effective Date Desired	Medical/Vision – <i>Circle your choice:</i>			Dental – <i>Circle your choice:</i>		Dependent Life @ \$1.20/month	Relationship e.g. "Son"	Last Name	First Name	MI	Birthdate	Sex	Social Security number of all enrollees (employee and all dependents that are enrolling)	
	Alliant SELECT	Alliant PLUS	Group Health ESSENTIALS	WDS	Willamette									
	Yes	Yes	Yes	Yes	Yes	Yes, Sold as unit for Whole Family	Employee							
	Yes	Yes	Yes	Yes	Yes		Spouse							
	Yes	Yes	Yes	Yes, Sold as unit for all Children	Yes, Sold as unit for all Children									
	Yes	Yes	Yes											
	Yes	Yes	Yes											

## Section C. If you have other insurance and you want to decline the medical or dental insurance, please read this section and sign as indicated:

You must have medical and/or dental coverage elsewhere in order to decline employee only coverage with PLU. I am currently covered under another medical and/or dental plan. Therefore, I decline  Medical and/or  Dental for myself. I do not want to enroll, even though PLU pays the majority of the employee premium for the base medical and dental plans. I understand that if I change my mind, I may not be able to enroll on the medical or dental plan until the next open enrollment period.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_ Name of Medical Carrier: \_\_\_\_\_ Name of Dental Carrier: \_\_\_\_\_

## Section D. Identify your beneficiaries for the basic life and accidental death & dismemberment (AD&D) insurance benefit provided by PLU:

PLU provides each eligible employee with Basic Life and AD&D Insurance Benefits of 1 times annual salary to a maximum of \$50,000. My beneficiary designations are as follows:

Primary Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_ Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

## Section E. Employees: Please read this section and sign the bottom of this form to certify it's content and complete the enrollment process:

- I certify that to help control the plan costs for my PLU benefits package, I am not enrolled in any other medical or dental plan.
- I authorize any insurance company, health plan, employer, hospital or physician to release all information with respect to me or my dependents that has a bearing on these benefits provided by PLU.
- I authorize PLU to reduce my salary in the amount necessary to pay for the coverages shown above. Such reductions are considered elective contributions under the PLU Reimbursement Plan. I understand that these salary reductions may not be revoked or changed during the Plan Year except following a change in my family status as defined by the IRS, including things like my marriage or divorce, the death of one of my dependents, the birth or adoption of a child, the termination or commencement of employment of my spouse, and the change in FTE status or the taking of an unpaid leave of absence by me or my spouse.
- I further authorize PLU to continue this election, and to make future adjustments in the amount of the salary reduction if the cost of coverage in any program selected changes if I do not file a new election form.
- If the cost of my share of the premiums for the plan and dependent enrollment I elect exceeds my salary, I agree to pay PLU directly according to PLU's payment policy.
- I understand that I am financially responsible for charges involving benefits and services that are not covered in whole or part by PLU's Carriers. I certify that the information here is correct to the best of my knowledge.

**X** Signature:

Date:

**X** Group Administrator's Signature:

Date: