KELLY

EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters

☐ New Subscriber ☐ Member adding line of coverage ☐ WAIVER *(Signature Required)* ☐ COBRA or State Continuation ☐ Retiree

Company Name:	Palmer Staffing Services	KELLY Company ID:	120039	Business Phone:	202-464-1000

1 EMPLOYEE

Last Name	First Name	MI	Suffix (Jr., Sr., etc.)

Street *Note: a PO Box is insufficient for any HSA, FSA, or HRA account* | Apt #

City | State | Zip Code | E-mail

Social Security # | Date of Birth (MM-DD-YY) | Gender M ☐ F ☐ | Marital Status Single ☐ Married ☐ Partner* ☐ | On your effective date, will you be actively at work on a full-time basis for this employer? Y ☐ N ☐ | Hrs/week

Home Phone | Full-time Hire Date (MM-DD-YY) | ***Employer Use Only:*** Requested Effective Date (MM-DD-YY) | KELLY USE ONLY: H

** Domestic partner coverage availability is based on carrier and employer authorization.*

2 DEPENDENTS

Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Sex	F/T Student (Y/N)**	Disabled (Y/N)	Tobacco (Y/N)	Dependent Elections Health	Dental	Vision	Primary Care Physician (POS or HMO plans only) Physician Name	PCP ID#	Existing Patient (Y/N)
	Subscriber												
								☐	☐	☐			
								☐	☐	☐			
								☐	☐	☐			
								☐	☐	☐			

*** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)*

Participating Dentist Name/Code/Office#: Existing Patient: Y ☐ N ☐

If Eligible for Medicare: Effective Date (Part A): Effective Date (Part B): Effective Date (Part D):

3 PLANS

HEALTH

Group# XR 000
Carrier Carefirst
Plan BCHMO OAMVI

☐ Individual
☐ Individual & Child(ren)
☐ Individual & Adult
☐ Family
☐ Over 65 & Working FT
☐ Over 65 & Retired
☐ Waive Coverage

DENTAL

Group#: N/A
Carrier
Plan

☐ Individual
☐ Individual & Child(ren)
☐ Individual & Adult
☐ Family
☐ Waive Coverage

VISION

Group# N/A
Carrier
Plan

☐ Individual
☐ Individual & Child(ren)
☐ Individual & Adult
☐ Family
☐ Waive Coverage

CDH Funding: ☐ HRA ☐ HSA **Contrib. Amount** $_____
☐ FSA **Contrib. Amount** $_____ ☐ DCAP $_____

	Plan Name	Benefit Amt	Smoker?
☐ Life AD&D		$	☐ Y
☐ Vol. Life		$	☐ Y
☐ Vol. AD&D		$	☐ Y
☐ Vol. Sp. Life		$	☐ Y
☐ Vol. Dep. Life		$	☐ Y
☐ STD		$	/ week
☐ Vol. STD		$	/ week
☐ LTD		$	/ month
☐ Vol. LTD		$	/ month
☐ Supp. Life/AD&D		$	
☐ Critical Illness			
☐ Accident			
☐ Identity Theft			
☐ On-Line Medical			

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Employee Occupation: | Employee Class: | Employee Salary:

Primary Beneficiary: Relationship:

Secondary Beneficiary: Relationship:

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name:

Who is covered? ☐ Self ☐ Spouse/Partner ☐ All Policy#

Effective Date: Term Date:

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that the dependents listed above are eligible to enroll in the plan(s) selected. I have read and understand the second page of this form, including the sections titled The Role of Kelly and Waiver of Insurance, which are incorporated here by reference. **If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.** **THIS IS NOT AN APPLICATION FOR INSURANCE**

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EMPLOYEE SIGNATURE: **DATE:**

EMPLOYER SIGNATURE / VERIFICATION: **DATE:**

8/5/15

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