Financial Network Group Health Plan
2018 Medical Annual Enrollment Form (10/31/2017)

Employee Information

Last Name:	First Name:	MI:
Address:	City:	St: Zip:
Date of Birth: / Social Security Number:	Phone:	Coverage Effective Date:
Email Address:	Annual Salary $ (or prior yr earnings)	☐ Full-Time ☐ Part-time Hours/Wk
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)	Gender: ☐ Male ☐ Female	Does your spouse work? ☐ Yes ☐ No
Do you have coverage elsewhere (such as your spouse's employer)? ☐ Yes (complete box D) ☐ No		

(A) Medical

Choose One	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
☐ HSAOAP3 5.5K -BCBSGA	☐ $2,041.98	☐ $4,288.19	☐ $3,981.87	☐ $6,228.06
☐ REQUEST Individual Quote	☐	☐	☐	☐
☐ REQUEST Small Grp(2 or more Quote-**Must Submit Together**)	☐	☐	☐	☐
☐ Waive Coverage				

(B) List All Eligible Family Members Enrolled For Medical

Name *(Last, First, MI):*	Gender M F	Birth Date *(Mo./Day/Yr.)*	Social Security #.	Relationship

(H) Authorization

I have been given the opportunity to enroll in the Financial Network Group Benefit Plan. I authorize Financial Network Group Benefit Plan to make any necessary deductions from my pay for elected coverages. Medical, and dental and other health and disability deductions will be deducted pre-tax from my pay unless I contact Human Resources to indicate a different election. I understand that I cannot change my benefit enrollment elections until the next open enrollment period unless I have a qualified change in status (which must be reported to Human Resources within 31 days of the event). I authorize payment of medical benefits to preferred providers where applicable, for those charges covered by my group insurance benefits. I authorize release, for the term of my coverage, to or by my physician or health care provider of any medical information including copies of medical records, or insurance carrier with information necessary to establish student eligibility. This authorization will remain valid during my term of coverage under my group insurance plan or 12 months, whichever is less. I or my authorized representative may request a copy of this authorization and a photocopy of this authorization will be considered valid.

Employee Signature (typed name serves as signature) Date

Forms may be submitted by clicking blue button:

Please remember in addition to your monthly premium there is an annual enrollment fee of $450/participant as well as a participant administration fee reflected on Confirmation Statement