UMR®
P.O. Box 30541
Salt Lake City, UT 30541

BENEFIT ENROLLMENT FORM

RATE CODE: ________________

HIRE DATE:____________________ ORIIGINAL EFFECTIVE DATE: __________________

EMPLOYER NAME: **ECTOR COUNTY** GROUP #: **4808**

SECTION I - EMPLOYEE INFORMATION

Last Name:_____________________________________**First:**__________________________ **Initial** _________

SSN:______________________________ **Gender:**___________ **DOB:** ____________________

Address:____

City: ____ **State:** __________________________________ **Zip:** _________

Home Phone: __________________________________ **Email:**____

SECTION II - MEDICAL/ DENTAL COVERAGE

□ **Employee Only** □ **Employee + Spouse** □ **Employee + Child(ren)** □ **Employee + Family** □ **I decline coverage**

Reason for Declination____

If you Elect dependent coverage, please complete section below.

Dependent Name	SSN	Sex	DOB	Relationship	Is Dependent Employed?
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
					☐Yes ☐ No
If dependent is employed, is he/she eligible for coverage through a group health plan?					☐Yes ☐ No

If Yes is checked above, please complete the OTHER COVERAGE INFORMATION Section on back of form.

SECTION III- YOUR APPROVAL

I hereby apply for coverage under the benefit plan above. I authorize my employer to make necessary payroll deductions to cover the cost of participation in the selected plan. I understand this agreement shall remain in effect until such time as changed in writing.

SIGNATURE: ____ **DATE:** __________________

OTHER COVERAGE INFORMATION

IF YOU OR ANY OF YOUR DEPENDENTS HAVE MEDICAL OR DENTAL COVERAGE ELSEWHERE, YOU MUST COMPETE THIS SECTION AND PROVIDE A COPY OF YOUR INSURANCE CARD.

HEALTH PLAN INFORMATION

Insurance Company Name: ____

Address: ____

Name of Insured: ____ **Identification #** ____________________

Group Policy # ________________________________ **Phone #** ________________________________

Effective Date of Coverage: Medical __________________ **Dental** ___________________

Coverage is on: ☐ **Self Only** ☐ **Self & Spouse** ☐ **Self & Child(ren)** ☐ **Dependents Only**

MEDICARE INFORMATION

Name of Insured ____ **If eligible, is person enrolled in:**

Federal Medicare Part A: ☐**Yes** ☐ **No** **Part A Effective Date:** ________________

Federal Medicare Part B: ☐**Yes** ☐ **No** **Part B Effective Date:** ________________

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