



# Open Enrollment Form 2021

This form confirms your healthcare plan(s) for the upcoming plan year. Please provide all the information below. **Additional enrollment forms may be required to complete your request.**

## 1. Employee Information (please print)

Legal Name (Last, First, MI)	
Mailing Address (Street, Apt. #, City, State, Zip)	
Personal Email	Phone

## 2. Benefit Plans - I Select the Following:

<p><b>Medical Plans</b></p> <input type="checkbox"/> Kaiser HMO <input type="checkbox"/> Anthem Blue Cross HMO Select <input type="checkbox"/> Anthem Blue Cross HMO CA. Care <input type="checkbox"/> Anthem Blue Cross PPO  <p><b>Employee Status</b></p> <input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + Family  <input type="checkbox"/> DECLINE MEDICAL COVERAGE	<p><b>Dental Plans</b></p> <input type="checkbox"/> Delta Dental HMO <input type="checkbox"/> Delta Dental PPO  <p><b>Employee Status</b></p> <input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + Family  <input type="checkbox"/> DECLINE DENTAL COVERAGE	<p><b>Vision Plans</b></p> <input type="checkbox"/> VSP   <input type="checkbox"/> Employee ONLY <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + Family  <input type="checkbox"/> DECLINE VISION COVERAGE
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## 3. Optional Additional Coverage Plans - Additional forms are required.

<p><b>The Hartford</b></p> <input type="checkbox"/> Hartford Life & Accident Insurance  <input type="checkbox"/> DECLINE THE HARTFORD COVERAGE	<p><b>Medical FSA</b></p> <input type="checkbox"/> Medical Flexible Spending Account  <input type="checkbox"/> DECLINE MEDICAL FSA	<p><b>Dependent Care FSA</b></p> <input type="checkbox"/> Dependent Care Flexible Spending Account  <input type="checkbox"/> DECLINE DEPENDENT CARE FSA
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## 4. Dependent Information

Dependent	Name (Last, First, MI)	Benefit
Spouse or Domestic Partner*		<input type="checkbox"/> Medical
		<input type="checkbox"/> Dental
		<input type="checkbox"/> Vision
* Legal documentation might be required.		
Child 1		<input type="checkbox"/> Medical
		<input type="checkbox"/> Dental
		<input type="checkbox"/> Vision
Child 2		<input type="checkbox"/> Medical
		<input type="checkbox"/> Dental
		<input type="checkbox"/> Vision
Child 3		<input type="checkbox"/> Medical
		<input type="checkbox"/> Dental
		<input type="checkbox"/> Vision

Employee's Signature:	Date:
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