ASCA Enrollment / Change Form

Office Use Only	
Enrollment	☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ Qualifying Event
Change	☐ Personal Information ☐ Beneficiary ☐ Add Dependent ☐ Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	☐ Marriage/Divorce ☐ Birth/Adoption ☐ Court Order ☐ Loss of Coverage ☐ FT to PT (last day of FT Coverage _____)

Employee Information			
Social Security Number	Last Name	First Name	MI
Home Street Address Apt		City, State, Zip	
Date of birth	Date of hire	Gender (required) ☐ Male ☐ Female	Salary $

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

Elections				
Premier Medical Plan	Value Medical Plan	Enhanced Dental	Basic Dental	Vision
☐ Employee Only $661.10	☐ Employee Only $583.32	☐ Employee Only $32.22	☐ Employee Only $23.37	☐ Employee Only $14.32
☐ Employee + Spouse $1,384.19	☐ Employee + Spouse $1,213.07	☐ Employee + Spouse $64.43	☐ Employee + Spouse $46.74	☐ Employee + Spouse $21.12
☐ Employee + Children $1,130.10	☐ Employee + Children $986.20	☐ Employee + Children $80.54	☐ Employee + Children $52.63	☐ Employee + Children $21.50
☐ Family $1,963.88	☐ Family $1,726.64	☐ Family $118.66	☐ Family $79.30	☐ Family $32.82
☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____

I have read this form and the other materials given to me about my benefits and certify the information I have supplied is correct. I understand that misstatements, misrepresentations, or omissions may result in my coverage being canceled. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary action up to and including termination.

I also understand that the benefit coverages I elect on this form will be in effect for the entire plan year unless I experience a qualified status change event and request a change to my benefits within 30 days of such event. By signing and submitting this enrollment form, I authorize ALVMA and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I understand that my contributions for the medical, dental and vision coverage (if elected) will be deducted pre-tax. I also understand that I am liable for these deductions pursuant to such authorization and acknowledge that it is my responsibility to verify that these payroll deductions are correct. I will notify human resources immediately in writing upon discovering any discrepancy.

Employee Signature: _____ Date: _____