All plans included on this election form may not be offered by your employer.
Please return your election form to your Employer or email it to Service@Gravelinefinancial.com

Employer Name	Effective Date of Enrollment/Cancellation/Change

Reason For Form

- ☐ Open Enrollment
- ☐ New Hire
- ☐ Termination of Employment/Coverage
- ☐ Add Dependent(s)
- ☐ Cancel Dependent(s)
- ☐ Other (Explain) ______________________
- ☐ Change of Address
- ☐ COBRA ELECTION

Employee

Last Name	First Name	Gender	Date of Birth	Social

Street Address	Apt #	City	Zip

Email Address	Phone Number	Date of Hire

Medical

Insurance Carrier ______________________

Plan Name ______________________

Who is enrolling in Medical

☐ Employee ☐ Spouse ☐ Number of Children

☐ WAIVER I do not wish to enroll in medical benefits. I understand I may not be able to enroll until the next open Enrollment or unless I experience a qualifying event and notify my employer within 30 days of the qualifying event date

Supplemental Medical Expense - GAP

Insurance Carrier ______________________

Plan Name ______________________

Who is enrolling in Medical

☐ Employee ☐ Spouse ☐ Number of Children

☐ WAIVER I do not wish to enroll in GAP benefits. I understand I may not be able to enroll until the next open Enrollment or unless I experience a qualifying event and notify my employer within 30 days of the qualifying event date

Dental

Insurance Carrier ______________________

Plan Name ______________________

Who is enrolling in Medical

☐ Employee ☐ Spouse ☐ Number of Children

☐ WAIVER I do not wish to enroll in Dental benefits. I understand I may not be able to enroll until the next open Enrollment or unless I experience a qualifying event and notify my employer within 30 days of the qualifying event date

Vision

Insurance Carrier ______________________

Plan Name ______________________

Who is enrolling in Medical

☐ Employee ☐ Spouse ☐ Number of Children

☐ WAIVER I do not wish to enroll in Vision benefits. I understand I may not be able to enroll until the next open Enrollment or unless I experience a qualifying event and notify my employer within 30 days of the qualifying event date

Life Insurance   Long Term Disability   Short Term Disability

☐ **Employer Paid Life/AD&D Coverage**

Employee Voluntary Life/ADD ☐ Yes, Amount Elected $ ______________

Spouse/Domestic Partner Voluntary Life/ADD ☐ Yes, Amount Elected $ ______________

Child Children Voluntary Life/ADD ☐ Yes, Amount Elected $ ______________

☐ Short Term Disability

☐ Long Term Disability

Annual Salary
Job Title

Designate your Primary Beneficiary

Last Name, First Name		Last Name, First Name	
Relationship	% of Benefit	Relationship	% of Benefit

Designate your contingent Beneficiary

Last Name, First Name		Last Name, First Name	
Relationship	% of Benefit	Relationship	% of Benefit

☐ I understand and agree that life insurance coverage for my eligible dependent(s) may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy. Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the insurance company, at my own expense. I understand that if coverage is applied for in the future, it must be during an Enrollment period or due to a life change event as defined by the policy, and that a waiting period may apply.

Section 125 Health FSA and Dependent Care Account

Healthy FSA

$________________________

Monthly Election

Dependent Day Care Account

$________________________

Monthly Election

I authorize payroll deductions from my earnings for any contributions I am making. I understand any contributions not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions. I further understand Section 125 Flexible Benefit Plan deductions will be in effect for the plan year and cannot be revoked unless I experience a qualifying event as defined in the plan document

	Last Name	First Name	M or F	Date of Birth	Social
Spouse	Last Name	First Name	M or F	Date of Birth	Social
Children	Last Name	First Name	M or F	Date of Birth	Social
	Last Name	First Name	M or F	Date of Birth	Social
	Last Name	First Name	M or F	Date of Birth	Social
	Last Name	First Name	M or F	Date of Birth	Social
	Last Name	First Name	M or F	Date of Birth	Social

Employee Signature	Signature	Date