Benefit Eligible Enrollment Form

1 **(Please Print)**

Name _____ (First) (Middle Initial) (Last)

Address _____ (Street)

_____

City/Sate _____ (Town) (State) (Zip)

Soc Sec # _____

Date of Birth _____ (Mo/Day?yeaR)

Phone cell _____

2

In case of emergency contact:

Name _____

Address _____

City/State/zip _____

Relationship _____

Phone ( ) _____ (Area Code)

3

Date begin work _____

Department _____

Position _____

Hours per week _____

(Circle one)

Rate of pay _____ Hourly Salary

☐ Full time ☒ ben elig. Part-time ☐ Seasonal (6 months or less)

4

Benefits/Withholding electives

(Check requested benefits if eligible)

Yes	No	
☐	☐	Health insurance
☐	☐	Life insurance
☐	☐	Deferred Comp
☐	☐	Union dues
☐	☐	Credit union
☐	☐	TSA - (Teachers only)
☐	☐	Direct deposit
☐	☐	Dental
☐	☐	Disability Insurance
☐	☐	_____
☐	☐	_____

For payroll dept use only

☐	Form W-4	☐	Letter of appointment
☐	Form M-4	☐	Sexual Harassment form
☐	Form I-9	☐	Direct Deposit form
☐	MCR or MTR Form	☐	Benefit Booklet
☐	OBRA - Mandatory (ING Form)	☐	MTA Dues Teachers Only
☐	Birth Cert/Soc Sec Card & Photo ID/ OR Passport	☐	Initial Cobra Letter
☐	Life insurance - Basic	☐	MCR Soc Sec Letter
☐	Life insurance - Voluntary Optional	☐	HIRD form Ck-off list
☐	Health insurance	☐	SEC 125 Mass Conn
☐	Dental Insurance	☐	Flexible Savings
		☐	Disability Ins

5

I hereby certify that I have been given an opportunity to apply for **group life insurance** coverage and the Town's **health plans**. I understand fully the benefits available to me under the plan. I decline to participate and hereby waive all benefits of the plan or plans indicated below. (Check and initial appropriate plan(s) being declined)

☐ Life Insurance is declined *(initials)* _____ ☐ Health insurance is declined (*initials*)_____

I understand that if I desire to apply for either of these insurance plans at a later date, (a) for life insurance: I will have to supply, at my own expense, evidence of insurability satisfactory to the Life Insurance Company before I can become insured or (b) for health insurance: I cannot enroll in a plan until the next open enrollment period or unless there is an event which qualifies under federal law.

_____ Signature - **ONLY** if declining insurance

_____ Date

Are you a retiree from the state, a city or a town in Massachusetts? ☐ Yes ☐ No

All of the information provided above is correct and true. I have been advised of the benefits available to me.

_____ Signature

_____ Date