



# ARBA Enrollment / Change Form

Office Use Only	
Enrollment	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event
Change	<input type="checkbox"/> Personal Information <input type="checkbox"/> Beneficiary <input type="checkbox"/> Add Dependent <input type="checkbox"/> Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	<input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> 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) <input type="checkbox"/> Male <input type="checkbox"/> Female	Salary \$

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Elections				
Premier Medical Plan	Value Medical Plan	Enhanced Dental	Basic Dental	Vision
<input type="checkbox"/> Employee Only \$711.98	<input type="checkbox"/> Employee Only \$635.84	<input type="checkbox"/> Employee Only \$31.64	<input type="checkbox"/> Employee Only \$27.14	<input type="checkbox"/> Employee Only \$11.79
<input type="checkbox"/> Employee + Spouse \$1,424.22	<input type="checkbox"/> Employee + Spouse \$1,256.70	<input type="checkbox"/> Employee + Spouse \$63.27	<input type="checkbox"/> Employee + Spouse \$54.29	<input type="checkbox"/> Employee + Spouse \$16.47
<input type="checkbox"/> Employee + Children \$1,305.93	<input type="checkbox"/> Employee + Children \$1,165.07	<input type="checkbox"/> Employee + Children \$79.59	<input type="checkbox"/> Employee + Children \$69.17	<input type="checkbox"/> Employee + Children \$16.73
<input type="checkbox"/> Family \$2,018.16	<input type="checkbox"/> Family \$1,785.92	<input type="checkbox"/> Family \$117.08	<input type="checkbox"/> Family \$101.36	<input type="checkbox"/> Family \$24.52
<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> Decline Reason: _____	<input type="checkbox"/> 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 ARBA 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: \_\_\_\_\_