BAS
Benefits Advisory Service

Dynamic Youth Community - Master Employee Benefits Form

please complete in full

New Enrollment Effective_____ Term – Last Day of *Coverage* _____ Add Dependent Effective_____ Address Change_____

Employee Name_____ SS#_____ DOB: _____ DOH: _____ Hrs/Wk_____ Gender_____

Salary_____ Title: _____Address, City, State, Zip_____

Medical: ☐ Oxford Liberty EPO ☐ Oxford Metro EPO ☐ **Waive**

Dental: ☐ Aetna PPO ☐ Aetna DMO – ***must pick primary dentist***

LIFE: ☒ Life ($50k) ☒ **LTD :** 90 day EP, 60% to $5k/mo

	Name	SSN	DOB	Gender	Coverage Selection	Dentist ID# (DHMO Only)
Spouse					Medical ☐ Dental ☐	
Dependent					Medical ☐ Dental ☐	
Dependent					Medical ☐ Dental ☐	
Dependent					Medical ☐ Dental ☐	

Other Medical Coverage:

Carrier:_____ ID#_____ Prior effective date:_____ Term date:_____

Employer Paid Life Insurance – Beneficiary Designation

Primary Beneficiaries:

1) Name_____SS#_____ Relationship:_____ Address:_____ Benefit %_____

2) Name_____SS#_____ Relationship:_____ Address:_____ Benefit %_____

Secondary Beneficiaries:

1) Name_____SS#_____ Relationship:_____ Address:_____ Benefit %_____

2) Name_____SS#_____ Relationship:_____ Address:_____ Benefit %_____

I represent that all the information supplied in this application is true and complete. I have personally designated the beneficiaries shown on this form (if applicable) and hereby request group insurance for myself and for my dependents listed on this form for selected coverages noted above. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward the insurance costs for the insurance provided for in the policy of group insurance issued to my employer. I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the carrier gives its written consent. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the carrier does not receive notice of the Enrollment/Change Request within a reasonable time following the event, my eligibility and my dependent's eligibility may be affected. Misrepresentations: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature:_____ Date:_____

Employer Signature:_____ Date:_____