



## MedCost Group Health Plan Election Form 2020-2021

Employee Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

All employees must complete this form and submit to the Human Resources Department.

**All rates listed below are per month.**

I elect to cover the following dependents on my **HEALTH** insurance plan (place an "X"):

Employee Only (\$0.00)     Employee & Child(ren) (\$411.00)     Waiving Coverage

I elect to cover the following dependents on my **DENTAL** insurance plan (place an "X"):

Employee Only (\$31.00)     Employee & Spouse (\$62.00)     Employee & Child(ren) (\$87.00)  
 Family (\$99.00)     Waiving Coverage

I elect to cover the following dependents on my **VISION** insurance plan (place an "X"):

Employee Only (\$0.00)     Employee & Spouse (\$6.00)     Employee & Child(ren) (\$6.00)  
 Family (\$13.00)     Waiving Coverage

List your dependents to be enrolled (please PRINT neatly):

### Employee

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### Spouse

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### Child 1

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### Child 2

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### Child 3

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### Child 4

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

### Company Paid Life Insurance (\$25,000 Benefit Amount) - Life Insurance Beneficiary Information:

Primary Beneficiary Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Beneficiary Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Employee Paid Life Insurance on Dependents (\$10,000 Benefit Amount - \$4.10 per month) \_\_\_\_\_ Yes \_\_\_\_\_ No