Dunn Companies

Employee Enrollment / Change / Waiver Form

Cypress Group #: _____ **Cypress Division:** _____ **Effective Date:** _____

Enrollment Type

☐ **New Hire** ☐ **Open Enrollment** ☐ **Qualifying Event** **Date Event Occurred:** _____

Employment Status:

☐ **Full-Time** ☐ **Part-Time** ☐ **Seasonal**

Type of Event:

☐ **Marriage** ☐ **Divorce** ☐ **Birth** ☐ **Death**

Employee Information (please print)

First Name	**Middle Initial**	**Last Name**	**Gender**	**Date of Birth**

Street Address	**City**	**State**	**Zip**

Email address	**Date of Hire**	**Social Security Number**

Marital Status	**Phone Number**
☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**	

Dependent Information (please print)

Only list your LEGAL dependents to be covered under the medical plan.

First Name	Last Name		Gender	Date of Birth	Social Security Number
First Name	Last Name	SPOUSE	Gender	Date of Birth	Social Security Number
First Name	Last Name	CHILD	Gender	Date of Birth	Social Security Number
First Name	Last Name	CHILD	Gender	Date of Birth	Social Security Number
First Name	Last Name	CHILD	Gender	Date of Birth	Social Security Number
First Name	Last Name	CHILD	Gender	Date of Birth	Social Security Number

Please mark the box next to the coverage you are electing

Medical & Prescription Drug Election and Plan Design

	Election	Hourly Employee Weekly Deduction
	Employee Only	$ 4.62
	Employee + Spouse	$56.31
	Employee + Child(ren)	$43.15
	Employee + Family	$75.00
	Waiver - Employee does not wish to elect Coverage Reason for Waiving:	

Office Visit Copay:	**$25**
Rx Copays:	**$10/35/55**
Deductible:	**$500 Individual / $1,500 family**
Out of Pocket:	**$2,500 Individual / $5,000 Family**
Hospital Inpatient:	**$250 Copay per Day up to 10 Days**
Outpatient:	**$250 Copay per Visit**
Emergency Room:	**$250 Copay per Visit**
Advanced Diagnostics:	**$250 Copay per Visit**

Please see SPD for full details

Other Coverage Information

This section must be filled out for anyone having other medical coverage, including Medicare coverage

Name of Policyholder	Effective Date of Policy	Name of Covered Person	Name of Insurance Company	Member ID/SSN

Employee Authorization

IMPORTANT!

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer/group. I proclaim that I was not pressured or forced by my employer/group, the writing agent or insurance company into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action. I understand that my pay will be reduced by the amount of any required contributions noted for the coverage(s) elected where the contributions are pre-tax. I understand that my coverage elections on this form cannot be revoked or modified during the year unless I have a qualifying change in status as defined by the IRS and I may change my coverage elections during the next open enrollment period.

_____ _____

Employee Signature **Date**

_____ _____

Employer Representative Signature **Date**

_____

Employer Representative Printed Name

Collier