SWIFT STAFFING EMPLOYEE HEALTH INSURANCE ELECTION FORM

☐ New Subscriber ☐ Member adding line of Coverage ☐ WAIVER(SIGNATURE REQUIRED) ☐ COBRA ☐ RETIREE

Section 1- EMPLOYEE

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____ Email _____

Social Security# _____ Date of Birth _____ Male ☐ Female ☐ Married ☐ Single ☐

Section 2 – Dependents

Name(Last, First, MI)	Relationship	Social Security#	Birth Date	Gender	FT Student	Disabled	Dependent Elections	
	Subscriber							

If Full time student, please submit proper form or appropriate verification of student is Eligible for Medicare Status according to carrier guidelines (statement from Registrars office, etc.)

Eligible for Medicare/ Effective Date (Part A) _____ Effective Date(Part B) _____ Effective Date (Part D) _____

Section 3 Plans

HEALTH
Kaiser Permanente

(Circle One)	***Select Level of Coverage***
Option A HDHP plan 10	☐ ***Individual***
Option B HDHP PLAN 07	☐ ***Individual & Children***
Option C DHMO Plan 13	☐ ***Individual & Adult***
	☐ ***Family***
	☐ ***Waive Coverage***

Section 4 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? ☐ *Yes* ☐ *No*

Other Health Insurer Name-_____ {Policy#_____

Who is Covered You ☐ *Spouse* ☐ *All* ☐ *Effective Date* ____/___/_____ *Term Date*_____/____/_____

CERTIFICATION: *I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part, I also agree to pay current and future charges for coverage(s) provided in access of any employer contribution. The recorded answers on this form are to be the best of knowledge and belief full, complete and true as of this date. D I further certify that I am the spouse/partner, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or executed under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.*

THIS IS NOT AN APPLICATION FOR INSURANCE.

Section 5

EMPLOYEE SIGNATURE/_____ DATE_____/____/____

EMPLOYER SIGNATURE – VERIFICATION _____ DATE_____/____/____