



# KELLY & ASSOCIATES INSURANCE GROUP, INC.

301 International Circle · Hunt Valley, Maryland 21030-1342 · (410) 527-3432 · Fax: (410) 527-5905 · www.kaig.com

## EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters

Please fill in the boxes completely:

New Subscriber

Member adding line of coverage

WAIVER (Signature Required)

COBRA

Retiree

Company Name: \_\_\_\_\_

KELLY Company ID#: \_\_\_\_\_

Business Phone#: ( ) \_\_\_\_\_

EMPLOYEE	1 Last Name		First Name		MI	Title (Jr., Sr., etc.)	
	Street Number		Street Name			Apt#	
	City			State	Zip Code	E-mail	
	Social Security#		Date of Birth (MM-DD-YY)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Partner* <input type="checkbox"/>	On your effective date, will you be actively at work on a full-time basis for this employer? <input type="checkbox"/> Y <input type="checkbox"/> N	Hrs/week
	Home Phone#		Full-time Hire Date (MM-DD-YY)	Requested Effective Date (MM-DD-YY)		KELLY USE ONLY: C	

\* Domestic partner coverage availability is based on carrier and employer authorization.

DEPENDENTS	2 Name (Last, First, MI)		Relationship	Social Security #	Birth Date	Gender	F/T Student (Y/N)**	Disabled (Y/N)	Dependent Elections	POS or HMO plans only: Line 1: PCP Line 2: OB/GYN		Existing Patient (Y/N)
			Subscriber						Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>	Physician Name	Physician #	
									<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
									<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
									<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
									<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

\*\* If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)

Participating Dentist Name/Code/Office#: \_\_\_\_\_

Existing Patient:  Y  N

If Eligible for Medicare: \_\_\_\_\_

Effective Date (Part A): / /

Effective Date (Part B): / /

Effective Date (Part D): / /

PLANS	3 HEALTH		DENTAL		VISION		Plan Name	Benefit Amount	Smoker?
	Grp#: _____		Grp#: _____		Grp#: _____		<input type="checkbox"/> Life AD&D	\$ _____	<input type="checkbox"/> Y
	Carrier: _____		Carrier: _____		Carrier: _____		<input type="checkbox"/> Vol. Life	\$ _____	<input type="checkbox"/> Y
	Plan: _____		Plan: _____		Plan: _____		<input type="checkbox"/> Vol. AD&D	\$ _____	<input type="checkbox"/> Y
	<input type="checkbox"/> Individual		<input type="checkbox"/> Individual		<input type="checkbox"/> Individual		<input type="checkbox"/> Vol. Sp. Life	\$ _____	<input type="checkbox"/> Y
	<input type="checkbox"/> Individual & Child(ren)		<input type="checkbox"/> Individual & Child(ren)		<input type="checkbox"/> Individual & Child(ren)		<input type="checkbox"/> Vol. Dep. Life	\$ _____	<input type="checkbox"/> Y
<input type="checkbox"/> Individual & Adult		<input type="checkbox"/> Individual & Adult		<input type="checkbox"/> Individual & Adult		<input type="checkbox"/> STD	\$ _____ /wk		
<input type="checkbox"/> Family		<input type="checkbox"/> Family		<input type="checkbox"/> Family		<input type="checkbox"/> Vol. STD	\$ _____ /wk		
<input type="checkbox"/> Over 65 & Working FT		<input type="checkbox"/> Family		<input type="checkbox"/> Family		<input type="checkbox"/> LTD	\$ _____ /mo		
<input type="checkbox"/> Over 65 & Retired		<input type="checkbox"/> Waive Coverage		<input type="checkbox"/> Waive Coverage		<input type="checkbox"/> Vol. LTD	\$ _____		
<input type="checkbox"/> Waive Coverage						<input type="checkbox"/> Suppl. Life/AD&D	\$ _____		

4 Employee Occupation _____	Employee Class _____	Employee Salary _____
Primary Beneficiary _____	Relationship _____	
Secondary Beneficiary _____	Relationship _____	

5 OTHER INSURANCE INFORMATION

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

Other Health Insurer Name \_\_\_\_\_

Who is covered?  Self  Spouse/Partner  All Policy# \_\_\_\_\_

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 excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. 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 excluded under this agreement, please contact a Service Representative before signing this Election Form.

**THIS IS NOT AN APPLICATION FOR INSURANCE**

6 EMPLOYEE SIGNATURE _____	DATE / /
EMPLOYER SIGNATURE / VERIFICATION _____	DATE / /