



**Group Name: Anderson County BOE**

**Benefits Enrollment Form**

**Please complete the following information:**

Social Security No.	Last Name	First	Middle	Date of Birth
Home Address		Home Phone		Gender
City	State	ZIP Code	Business Phone	

**List All Your Eligible Dependents That Are To Be Covered**

First	MI	Last	Facility Number	Sex	Birth Date
Spouse:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
Effective Date: (Agent to fill in)		Group Number (Agent to fill in)	Your E-mail Address		Agent Number <b>1024303 / 1284915</b>

PLEASE CHECK YOUR CHOICE	<input type="checkbox"/> Dental Plan 1 Year Rate	<input type="checkbox"/> Vision Plan 2 Year Rate
	Monthly Rates	11/1/11-10/31/2012
Employee Only	<input type="checkbox"/> \$22.85	<input type="checkbox"/> \$7.28
Employee + One	<input type="checkbox"/> \$51.96	<input type="checkbox"/> \$14.57
Employee + Family	<input type="checkbox"/> \$77.28	<input type="checkbox"/> \$19.52

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

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