MULTITECH MECHANICAL SUPPORT

Registration Form for Health Insurance

Full Name:_____ Social Security N◦:_____

Address:_____

City, State, Zip Code:_____ Date of Birth:_____

Phone Number:_____ Start Date:_____

Sex: M□ F□ Filling Status: Single □ Married□ Divorced□ Separated□

Information of dependents

Complete the following information for each dependent you wish to enroll.

	Full Name	Sex M/F	Date of Birth	SSN
Spouse				
child				
child				
child				
child				
child				
Other				

Choice of Health Insurance: **Basic Plan** □ **High Plan** □

Life Insurance Beneficiary: Name:_____ **SSN:**_____

Authorization Section

With my signature I authorize my employer to ENROLL ME in the chosen coverage. I authorize the corresponding insurance premium to be deducted from my check. I understand that I will not be able to make changes to this election unless it happens in the family as defined by the IRS. I also understand that if a change occurs in my family, I must notify my Employer within 30 days of that change.

Signature:_____ Date:_____

I choose NOT to ENROLL in the insurance for: Price □ Other Insurance □

Signature:_____ Date:_____