ENROLLMENT FORM
KIER CONSTRUCTION CORP
GROUP NUMBER: SFKIR

TALL TREE ADMINISTRATORS

SECTION 1 - EMPLOYEE INFORMATION

Name (Last, First, MI):		
Gender: ☐ Male ☐ Female	DOB (MM/DD/YY) / /	SS#: - -
Address:		
City: State: Zip:		Daytime Phone:
Hire Date: / /		Eligibility Effective Date: / /
Email address:		

SECTION 2 – COVERAGE ELECTIONS OR WAIVER OF COVERAGE

	Single	EE + Spouse	EE + Child(ren)	Family
Medical/Dental/Vision				
Dental/Vision				

COVERAGE DECLINED

☐ **Medical**	☐ **Dental/Vision**

I have decided not to apply for coverage at this time for myself or my dependents (if any). I have coverage from: (check one)
☐ Medicare ☐ Medicaid ☐ Spouse Plan ☐ Parent Plan ☐ Individual Plan ☐ Military Plan

I have decided to waive coverage at this time for myself and my dependents.
Note: You will not be able to enroll until the next open enrollment or you have a Qualified Event.

Employee must sign here ***only if you are*** declining coverage

X	Date:

SECTION 3 – LEGAL SPOUSE'S INFORMATION

Name (Last, First, MI):		
Gender: ☐ Male ☐ Female	DOB (MM/DD/YY) / /	SS#: - -
Name of Spouse's Employer (or "Not Employed"):		

Is there other insurance ☐ Yes ☐ No
If spouse is covered by another Health Insurance Plan you must complete the "Other Insurance" section.

SECTION 4 – LEGAL DEPENDENT CHILDREN INFORMATION

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

SECTION 5 - EMPLOYEE SIGNATURE

Please read carefully before signing: I certify that the information on this enrollment form is true and complete. I hereby apply for this coverage. I authorize my employer to make the necessary payroll deductions. I authorized any health care provider to release all information pertaining to care provided to me or my dependents. A photocopy of this authorization shall be valid as the original.

X	Date:

I understand I may not drop my coverage unless there is a Qualifying Event (QE) or the Plan has an Open Enrollment period. Changes must be submitted within 30 days of Qualifying Event

SECTION 6 – OTHER INSURANCE INFORMATION

Name of Health Plan:		
Group or policy #:	Phone Number:	Date Coverage Began:

Name of all individuals covered under this plan an any additional explanations or information about this coverage:

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

SECTION 7 – ELECTRONIC DATA INFORMATION

For your security and privacy you can log into our secure website to view your eligibility, view claim history and access your Explanation of Benefits for any claim that has been processed for you or your family members. In addition, you will be linked to the PPO network and other valuable information. Visit www.talltreehealth.com.

OFFICE USE ONLY

☐ Regular Enrollment: Completed within 31 days of eligible date.	Effective Date:
Annual Salary	☐ Hourly ☐ Salary

Locations:		
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

Employer Group Representative Signature	
X	Date: