



# GEMINI TECH EMPLOYEE ENROLLMENT FORM

## Full-Time Employees

**PLEASE PRINT LEGIBLY**

### TO BE COMPLETED BY THE EMPLOYEE

#### EMPLOYEE INFORMATION

<i>Employer Name</i>				
<i>Employee Last Name</i>		<i>Employee First Name</i>		<i>MI</i>
<i>Date of Birth</i>	<i>Social Security Number</i>		<i>Gender</i>	<i>Base Salary</i>
/ /	- -	<input type="checkbox"/> Male <input type="checkbox"/> Female	\$ ,	
<i>Street Address</i>			<i>Date of Hire</i>	
			/ /	
<i>City</i>		<i>State</i>	<i>Zip Code</i>	
			-	
<i>Email</i>			<i>Phone</i>	
			-	

#### BENEFIT SELECTION

<b>Major Medical EPO 8000 Core</b>	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Family Coverage	<input type="checkbox"/> N/A - Decline Coverage
<b>Major Medical PPO 6029 Buy Up</b>	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Family Coverage	<input type="checkbox"/> N/A - Decline Coverage
<b>Dental – PPO</b>	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Family Coverage	<input type="checkbox"/> N/A - Decline Coverage
<b>Vision</b>	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Family Coverage	<input type="checkbox"/> N/A - Decline Coverage
<b>EAP</b>	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Family Coverage	<input type="checkbox"/> N/A - Decline Coverage
<b>Life/AD&amp;D</b>	<input type="checkbox"/> Employee Only	<b>Benefit is mandatory for Full-Time Employees</b>			
<b>Short-Term Disability</b>	<input type="checkbox"/> Employee Only	<b>Benefit is mandatory for Full-Time Employees</b>			
<b>Long-Term Disability</b>	<input type="checkbox"/> Employee Only	<b>Benefit is mandatory for Full-Time Employees</b>			

**Note:** If you are declining Major Medical coverage, you must complete the waiver form and provide proof of other major medical insurance from your spouse's employer, VA Service Connected Medical Coverage, or Tricare Coverage. Your waiver will not be accepted without a completed & signed waiver form and proof of other valid coverage. Employee Only coverage is paid for by your employer's H&W contribution. If you choose to elect dependents to your coverage, these costs will be payroll deducted.

**Specialty Benefits Include:** MetLife Dental, MetLife Vision, (EAP) Employee Assistance Program, MetLife Short-Term & Long-Term Disability, and MetLife Life/AD&D.

#### LIFE INSURANCE BENEFICIARY INFORMATION

##### Beneficiary Designation

<i>Primary Beneficiary Last Name</i>	<i>Primary Beneficiary First Name</i>	<i>MI</i>	<i>Relationship</i>
<i>Contingent Beneficiary Last Name</i>	<i>Contingent Beneficiary First Name</i>	<i>MI</i>	<i>Relationship</i>

## DEPENDENT INFORMATION

Do you wish to cover your eligible dependents?  Yes  No If yes, complete the following:

Spouse/Domestic Partner Last Name				Spouse/Domestic Partner First Name				MI
Date of Birth / /		Social Security Number - -		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Child Last Name				Child First Name				MI
Date of Birth / /		Social Security Number - -		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Child Last Name				Child First Name				MI
Date of Birth / /		Social Security Number - -		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Child Last Name				Child First Name				MI
Date of Birth / /		Social Security Number - -		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				
Child Last Name				Child First Name				MI
Date of Birth / /		Social Security Number - -		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				

I would like to cover additional eligible dependents (PLEASE LIST ON A SECOND ENROLLMENT FORM)

## EMPLOYEE STATEMENTS AND AGREEMENTS

I understand the effective date of coverage will be determined by the terms and eligibility requirements of the Master Policy.  
 I understand that changes to my Benefit Selections can only be made following a Qualifying Life Event.  
 I authorize deductions from my earnings at the required contributions towards the cost of the coverage.  
 I certify that I am eligible to participate and that the above information is correct.

Signature	Date
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TO BE COMPLETED BY THE EMPLOYER			
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add ○ Dependent(s)	<input type="checkbox"/> Change ○ Address ○ Phone ○ Name ○ Cobra	<input type="checkbox"/> Cancel Coverage ○ Policy Holder ○ Dependent(s)
Reason for Change	<input type="checkbox"/> Employment Status <input type="checkbox"/> Qualifying Event: (PLEASE STATE EVENT AND ATTACH PROOF) _____		
A Qualifying Life Event (QLE) is a term defined by the IRS to describe events that may allow participants to change their benefit elections outside of an Open Enrollment period. Examples include: a change in family status that results in an increase or decrease in number of eligible family members, including, but not limited to: adoption, birth, marriage or divorce and death.			
Requested Effective Date / /	Date of Employment / /		