THE Contractors PLAN®
Provided by Fringe Benefit Group

GEMINI TECH EMPLOYEE ENROLLMENT FORM

Part-Time Employees

PLEASE PRINT LEGIBLY

TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE INFORMATION

Employer Name			
Employee Last Name	*Employee First Name*	*MI*	
Date of Birth / /	*Social Security Number* - -	*Gender* ◯ Male ◯ Female	*Base Salary* $,
Street Address		*Date of Hire* / /	
City	*State*	*Zip Code* -	
Email		*Phone* -	

BENEFIT SELECTION

Dental – PPO	◯ Employee Only	◯ Employee + Spouse	◯ Employee + Children	◯ Family Coverage	◯ N/A - Decline Coverage
Vision	◯ Employee Only	◯ Employee + Spouse	◯ Employee + Children	◯ Family Coverage	◯ N/A - Decline Coverage
EAP	◯ Employee Only	◯ Employee + Spouse	◯ Employee + Children	◯ Family Coverage	◯ N/A - Decline 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.
Benefits Include: MetLife Dental, MetLife Vision, and (EAP) Employee Assistance Program.

LIFE INSURANCE BENEFICIARY INFORMATION

Beneficiary Designation

Primary Beneficiary Last Name	*Primary Beneficiary First Name*	*MI*	*Relationship*
Contingent Beneficiary Last Name	*Contingent Beneficiary First Name*	*MI*	*Relationship*

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* ◯ Male ◯ Female
Child Last Name	*Child First Name*	*MI*
Date of Birth / /	*Social Security Number* - -	*Sex* ◯ Male ◯ Female
Child Last Name	*Child First Name*	*MI*
Date of Birth / /	*Social Security Number* - -	*Sex* ◯ Male ◯ Female
Child Last Name	*Child First Name*	*MI*
Date of Birth / /	*Social Security Number* - -	*Sex* ◯ Male ◯ Female
Child Last Name	*Child First Name*	*MI*
Date of Birth / /	*Social Security Number* - -	*Sex* ◯ Male ◯ 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*

TO BE COMPLETED BY THE EMPLOYER

◯ **New Enrollment**	◯ **Add** ☐ Dependent(s)	◯ **Change** ☐ Address ☐ Phone ☐ Name ☐ Cobra	◯ **Cancel Coverage** ☐ Policy Holder ☐ Dependent(s)

Reason for Change

☐ Employment Status
☐ 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* / /