Group HPFFA MEDICAL TRUST 341

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		Facility Number

List All Your Eligible Dependents That Are To Be Covered			
First MI Last	Facility Number	Sex	Birth Date
Spouse:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /

Effective Date:	Plan Code:	Group Number	Your E-mail Address	Agent Number

PLEASE CHECK YOUR CHOICE	☐ Dental CS600	☐ Dental Schedule D	☐ Dental EC 705	☐ Vision
Employee	☐	☐	☐	☐
Employee + One	☐	☐	☐	☐
Employee + Family	☐	☐	☐	☐

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: ______________