KEY BENEFIT ADMINISTRATORS

KEYSOLUTION™

5M Program - Enrollment Form

1. Enrollee Information

Group Name:		Plan Coverage Effective Date:	
Last Name:		Date you became a Full time Employee:	
First Name:		Date of Birth (DOB):	
Sex: ☐M ☐F	SS #:	No. Hours Work/per week:	
Home Phone #:		Work Phone #:	
Street Address:	City:	State:	Zip:

Plan Selection (per your enrollment guide):

MEC Plan ☐	**MEC Plus Plan** ☐	**MEC Heavy** ☐	**MEC Heavy Plus Plan** ☐	**MVP Plan** ☐

Beneficiary of Life Insurance *(If applicable)*:

Full Name:	Address:	City, State Zip:
Phone #:	Date of Birth:	Relationship:

2. Dependent Information

I would like to be covered under this plan along with the following dependents:

☐Spouse ☐Domestic Partner	Last Name:	First:	SS#:	DOB:	☐Male ☐Female
Last Name:		First:	SS#:	DOB:	☐Male ☐Female
☐Child ☐Disabled[1] ☐Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	☐Male ☐Female
☐Child ☐Disabled[1] ☐Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	☐Male ☐Female
☐Child ☐Disabled[1] ☐Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	☐Male ☐Female
☐Child ☐Disabled[1] ☐Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	☐Male ☐Female
☐Child ☐Disabled[1] ☐Court Ordered[2]					

[1]For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.

[2]If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for benefit plan participation for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

Employee (print name): ______________________________ **Employee Signature:** __________________________ **Date**:_____________