EBMS
Employee Benefit Management Services, Inc.

P.O. Box 21367 Billings, MT 59104-1367
Phone: 800.777.3575 or 406.245.3575 ● Website: *www.ebms.com*

BENEFIT ENROLLMENT FORM

Company Name: **Matanuska Susitna Borough**	Group #: **0000326**	Cert#:

This Section Is To Be Completed By Employee

Last Name	First Name	M.I.	Gender	Marital Status ☐ Single-S ☐ Married-M ☐ Divorced-D ☐ Legally Separated
SSN:	Date of Birth:		Email Address:	

Current Mailing Address: City: State Zip:

Home Phone ( ) Work Phone ( ) (ext)

Please Indicate the Coverage Elected :

List of Eligible Dependents Full Name	Social Security # *Required	Gender	Date of Birth *Required	Relationship to Employee	Medical	Dental and Vision	Verifying Documentation received

Other Health Benefit Information

Are you or any of your dependents enrolled in another health benefit plan? ☐ Yes If yes, please indicate other insurance coverage below.

Are any of your dependent children **eligible** for other Employer Sponsored Coverage ☐ No ☐ Yes If yes, please indicate other insurance coverage (OIC) below.

If other insurance coverage (OIC) information is not indicated on this enrollment form, this will imply that no other insurance coverage (OIC) is in effect and/or that no dependent children are eligible for other Employer Sponsored Coverage.

Last Name	First Name	Other Health Benefit Name, Policy Number and Phone Number:	Medicare A	Medicare B	Medical	Dental	Vision
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

For the Other Insurance Coverage, please complete the following. For more than one insurance continue on the back of this form.

Other Policy Holder's name: Other Policy Holder's Date of Birth: / /

Type of Policy: ☐ Employer Sponsored ☐ Retiree ☐ COBRA ☐ Individual ☐ Medicaid/CHIP/Other State Program

Relationship of Policy Holder to those covered: Effective Date of Policy: / /

Application is made for benefits under Employer's benefit plan for which I am eligible and authorization is granted to deduct from my salary or wages any pre-tax premiums required. By signing below I am indicating that, to the best of my knowledge, all information is true and accurate. I understand that if the information provided herein is determined to be inaccurate, this will be considered an intentional misrepresentation and coverage could be terminated retroactively.

Signature **Date**

This Section Is To Be Completed By Employer

Division Name: Division #: Date of Hire: / / Employee ID#: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ On Leave Effective Date: / /

Change Request – Effective Date of Change / / **Please Check One Or More Of The Following Change Reasons:**

□ Addition □ Newborn □ Deletion □ Marriage: Date / / □ Name/Address Change □ Other: