

MULTITECH MECHANICAL SUPPORT

Registration Form for Health Insurance

Full Name: _____ Social Security No: _____

Address: _____

City, State, Zip Code: _____ Date of Birth: _____

Phone Number: _____ Start Date: _____

Sex: M ☐ F ☐

Filling Status: Single ☐ Married ☐ Divorced ☐ Separated ☐

Information of dependents

Complete the following information for each dependent you wish to enroll.

	Full Name	Sex M/F	Date of Birth	SSN
Spouse				
child				
child				
child				
child				
child				
Other				

Choice of Health Insurance: Basic Plan ☐ High Plan ☐

Life Insurance Beneficiary: Name: _____ SSN: _____

Authorization Section

With my signature I authorize my employer to ENROLL ME in the chosen coverage. I authorize the corresponding insurance premium to be deducted from my check. I understand that I will not be able to make changes to this election unless it happens in the family as defined by the IRS. I also understand that if a change occurs in my family, I must notify my Employer within 30 days of that change.

Signature: _____ Date: _____

I choose NOT to ENROLL in the insurance for: Price ☐ Other Insurance ☐

Signature: _____ Date: _____