EMPLOYEE INFORMATION FORM FOR BENEFITS

MEDICAL AND/OR DENTAL INSURANCE ENROLLMENT

Please provide information on the family members you'd like to cover on Cairn medical and dental insurance. Begin with yourself.

Employee Name: Last, First, Middle	Gender (M/F)	Self	Social Security Number	Date of Birth

Complete after enrollment mtg.				
MEDICAL	✓ Enroll PPO*			Check if current patient.
	✓ Enroll HMO*			
	✓ Waive Med.	(HMO Only) Primary Care Physician Office I.D. Number	(HMO Only) Primary Care Physician Office Name	
DENTAL	✓ Enroll DMO*			Check if current patient.
	✓ Enroll PPO*			
	✓ Waive Dent.	(DMO Only) List dentist name, practice name, and office address.		

Dependent Name: Last, First, Middle	Gender (M/F)	Spouse (Sp) or Child (Ch)	Social Security Number	Date of Birth

Complete after enrollment mtg.				
MEDICAL	✓ Enroll PPO*			Check if cur- -rent patient
	✓ Enroll HMO*	(HMO Only) Primary Care Physician Office I.D. Number	(HMO Only) Primary Care Physician Office Name	
DENTAL	✓ Enroll DMO*			Check if current patient.
	✓ Enroll PPO*			
	✓ Waive Dent.	(DMO Only) List dentist name, practice name, and office address.		

Dependent Name: Last, First, Middle	Gender (M/F)	Spouse (Sp) or Child (Ch)	Social Security Number	Date of Birth

Complete after enrollment mtg.				
MEDICAL	✓ Enroll PPO*			Check if cur- -rent patient
	✓ Enroll HMO*	(HMO Only) Primary Care Physician Office I.D. Number	(HMO Only) Primary Care Physician Office Name	
DENTAL	✓ Enroll DMO*			Check if current patient.
	✓ Enroll PPO*			
	✓ Waive Dent.	(DMO Only) List dentist name, practice name, and office address.		

Dependent Name: Last, First, Middle	Gender (M/F)	Spouse (Sp) or Child (Ch)	Social Security Number	Date of Birth

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	✓ Enroll HMO*	(HMO Only) Primary Care Physician Office I.D. Number	(HMO Only) Primary Care Physician Office Name	
DENTAL	✓ Enroll DMO*			Check if current patient.
	✓ Enroll PPO*			
	✓ Waive Dent.	(DMO Only) List dentist name, practice name, and office address.		

Dependent Name: Last, First, Middle	Gender (M/F)	Spouse (Sp) or Child (Ch)	Social Security Number	Date of Birth

Complete after enrollment mtg.				
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	✓ Enroll HMO *	(HMO Only) Primary Care Physician Office I.D. Number	(HMO Only) Primary Care Physician Office Name	
DENTAL	✓ Enroll DMO			Check if current patient.
	✓ Enroll PPO			
	✓ Waive Dent.	(DMO Only) List dentist name, practice name, and office address.		

Pre-Tax Deduction Authorization	Flexible Spending Account (Please complete the FSA Enrollment Form)	403(b) Retirement Plan
☐ I ELECT the pre-tax option.	☐ I elect the Healthcare Account	I authorize pre-tax salary reduction of this amount: ____ %
☐ I DECLINE the pre-tax option.	☐ I elect the Dependent Care Account	I authorize post-tax (Roth) salary reduction of this amount: ____ %
☐ Does not apply at this time.	☐ I waive participation in the FSA.	☐ I decline participation (or wish to stop contributing) *at this time.*

SIGNATURE	DATE SIGNED	If above notes changes, when do changes take effect?

* Employee (member) coverage is subject to the terms and conditions of the applicable health benefit contract which, in the case of the HMO and DMO coverage, provides that, except for emergencies, all medical/dental care must be initiated at the primary care office or primary dental office selected by the member.
A medical insurance-enrolled employee (member) authorizes Independence Blue Cross of PA to obtain, use, and disclose member-related health and medical information for benefit administration, claims payment, utilization review, and quality assurance purposes.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.