


EMPLOYEE INFORMATION				BENEFIT ADMINISTRATOR SECTION		
LAST NAME		FIRST NAME		MI	PLAN YEAR <b>1/1/2019 – 12/31/2019</b>	GROUP # <b>14515</b>
MERITAIN HEALTH ID NUMBER/SSN		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH		EFFECTIVE DATE	DIVISION #
HOME ADDRESS			EMAIL ADDRESS		DATE OF HIRE	
CITY		STATE	ZIP CODE		PAY CYCLE <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> OTHER: _____	
HOME TELEPHONE		WORK TELEPHONE				

**Please check all that apply:**

<input type="checkbox"/> TRANSPORTATION REIMBURSEMENT ACCOUNT					
Benefit	Yes/No	Rollover	Annual Election	No. of paychecks	Paycheck deduction
<b>Parking account</b> Maximum of \$265.00 per month	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>YES</b>	\$ _____ per plan year	_____	\$ _____ per paycheck
<b>Transit account</b> Maximum of \$265.00 per month	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>YES</b>	\$ _____ per plan year	_____	\$ _____ per paycheck

EMPLOYEE SIGNATURE REQUIRED	
<p>I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.</p>	
EMPLOYEE SIGNATURE 	DATE