Cherokee Insurance Company

Low, Standard, High Deductible Plans

2015 MEDICAL / DENTAL ELECTION FORM

New Hire ☐ Change ☐

1.) Employee (Subscriber) Information

First Name	Last Name	Marital Status	SSN #
		( )	- -

Mailing Address	Date of Birth	Phone #
	/ /	( ) -

City, State Zip	Employer Name
	( )

Hire Date (HR use only)		
/ /		
Group	Div	CO#
EMP ID	EFF DATE	
	/ /	

2.) Select Plan

	Low ☐	Standard ☐	High ☐
Medical	Single ☐	Double ☐	Family ☐
Dental	Single ☐	Double ☐	Family ☐

3.) Participants

Relationship	First Name, Last Name	Date of Birth	Sex	Coverage wanted	Has other coverage?	SSN#
Subscriber		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -
Spouse		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -
( )		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -
( )		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -
( )		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -
( )		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -
( )		/ /	M ☐ F ☐	MEDICAL: ☐ DENTAL: ☐	Y ☐ N ☐	- -

4.) Non-participation ☐ Effective Date: ____/____/____

I do not wish to participate in the employee benefit

Signature *Date*

5.) Participation ☐

I herby request the coverage indicated above, and authorize my employer to deduct the contributions upon the effective date

Signature *Date*

6.) Other Coverage Form *Check all boxes that apply.*

Name of Dependent	Your relationship to the dependent	Other insurance name	Who is providing other coverage	Medical	Dental	Vision	Drugs
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Additional information required to provide insurance for your dependents.

A. Who is legally responsible for coverage. _____
If a court order has determined who is legally responsible, please attach copy of the document.

B. If other parent is providing coverage and is not listed on the form, please provide their DOB: ____/____/__

C. Please note that custodial parents provide primary insurance coverage and non custodial parents provide secondary.

Required information needed to process your Insurance Election form.

- **If your dependents have other coverage you must fill out the section located at the top of this page.**
- **If your spouse's last name is different please provide a copy of the marriage license.**
- **If your dependents last name is different please provide a copy of the birth certificate.**

Medical
2015 Weekly Contributions

	Single	Double	Family (3)	Family (4)	Family (5+)
Low Plan	$78.00	$112.00	$126.00	$136.00	$144.00
Standard Plan	$60.00	$84.00	$94.00	$104.00	$114.00
High Plan	$46.00	$60.00	$66.00	$74.00	$82.00

Dental
2015 Weekly Contributions

	Single	Double	Family (3)	Family (4)	Family (5+)
All Plans	$6.00	$12.00	$16.00	$18.00	$20.00