



KELLY & ASSOCIATES INSURANCE GROUP, INC.

301 International Circle · Hunt Valley, Maryland 21030-1342 · (410) 527-3432 · Fax: (410) 527-5905 · www.kaig.com

EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters

Please fill in the boxes completely:

New Subscriber

Member adding line of coverage

WAIVER (Signature Required)

COBRA

Retiree

Company Name: KELLY Company ID#: Business Phone#: ()

1 Last Name First Name MI Title (Jr., Sr., etc.)

Street Number Street Name Apt#

City State Zip Code E-mail

Social Security# Date of Birth (MM-DD-YY) Gender M F Marital Status Single Married Partner* On your effective date, will you be actively at work on a full-time basis for this employer? Y N Hrs/week

Home Phone# Full-time Hire Date (MM-DD-YY) Requested Effective Date (MM-DD-YY) KELLY USE ONLY: D

* Domestic partner coverage availability is based on carrier and employer authorization.

D E P E N D E N T S	Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Gender	F/T Student (Y/N)**	Disabled (Y/N)	Dependent Elections			POS or HMO plans only:		Existing Patient (Y/N)
								Health	Dental	Vision	Line 1: PCP	Line 2: OB/GYN	
											Physician Name	Physician #	
		Subscriber						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)

Participating Dentist Name/Code/Office#: Existing Patient: Y N

If Eligible for Medicare: Effective Date (Part A): / / Effective Date (Part B): / / Effective Date (Part D): / /

P L A N S	HEALTH	DENTAL	VISION	Plan Name	Benefit Amount	Smoker?
	Grp#: <input type="text"/>	Grp#: <input type="text"/>	Grp#: <input type="text"/>	<input type="checkbox"/> Life AD&D	<input type="text"/>	\$ <input type="text"/>
Carrier: <input type="text"/>	Carrier: <input type="text"/>	Carrier: <input type="text"/>	<input type="checkbox"/> Vol. Life	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/> Y
Plan: <input type="text"/>	Plan: <input type="text"/>	Plan: <input type="text"/>	<input type="checkbox"/> Vol. AD&D	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/> Y
<input type="checkbox"/> Individual	<input type="checkbox"/> Individual	<input type="checkbox"/> Individual	<input type="checkbox"/> Vol. Sp. Life	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/> Y
<input type="checkbox"/> Individual & Child(ren)	<input type="checkbox"/> Individual & Child(ren)	<input type="checkbox"/> Individual & Child(ren)	<input type="checkbox"/> Vol. Dep. Life	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/> Y
<input type="checkbox"/> Individual & Adult	<input type="checkbox"/> Individual & Adult	<input type="checkbox"/> Individual & Adult	<input type="checkbox"/> STD	<input type="text"/>	\$ <input type="text"/> /wk	
<input type="checkbox"/> Family	<input type="checkbox"/> Family	<input type="checkbox"/> Family	<input type="checkbox"/> Vol. STD	<input type="text"/>	\$ <input type="text"/> /wk	
<input type="checkbox"/> Over 65 & Working FT	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> LTD	<input type="text"/>	\$ <input type="text"/> /mo	
<input type="checkbox"/> Over 65 & Retired	CDH Funding: <input type="checkbox"/> HSA <input type="checkbox"/> FSA	Plan Year Election Amount \$ <input type="text"/>	<input type="checkbox"/> Vol. LTD	<input type="text"/>	\$ <input type="text"/>	
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> HRA <input type="checkbox"/> FSA	Plan Year Election Amount \$ <input type="text"/>	<input type="checkbox"/> Suppl. Life/AD&D	<input type="text"/>	\$ <input type="text"/>	

4 Employee Occupation Employee Class Employee Salary

Primary Beneficiary Relationship

Secondary Beneficiary Relationship

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? Yes No

Other Health Insurer Name

Who is covered? Self Spouse/Partner All Policy#

Effective Date / / Term Date / /

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that I am the spouse/partner, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.

THIS IS NOT AN APPLICATION FOR INSURANCE

6 EMPLOYEE SIGNATURE DATE / /

EMPLOYER SIGNATURE / VERIFICATION DATE / /