



## KeySolution Enrollment Form

### 1. Enrollee Information

Group Name:		Plan Coverage Effective Date:	
Last Name:		Date you became a Full time Employee:	
First Name:		Date of Birth (DOB):	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SS #:	No. Hours Work/per week:	
Home Phone #:		Work Phone #:	
Street Address:		City:	State:      Zip:

**Plan Selection** (per your enrollment guide):

MEC <input type="checkbox"/>
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**Beneficiary of Life Insurance** (If applicable):

Full Name:	Address:	City, State Zip:
Phone #:	Date of Birth:	Relationship:

### 2. Dependent Information

I would like to be covered under this plan along with the following dependents:					
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name:	First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled <sup>1</sup> <input type="checkbox"/> Court Ordered <sup>2</sup>					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled <sup>1</sup> <input type="checkbox"/> Court Ordered <sup>2</sup>					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled <sup>1</sup> <input type="checkbox"/> Court Ordered <sup>2</sup>					
Last Name:		First:	SS#:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child <input type="checkbox"/> Disabled <sup>1</sup> <input type="checkbox"/> Court Ordered <sup>2</sup>					

<sup>1</sup>For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.

<sup>2</sup>If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for benefit plan participation for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

I am waiving/declining coverage for myself and my dependents

**Employee** (print name): \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_