Options Plus
MEC APPLICATION

EMPLOYEE INFORMATION

Company: ______________________________

First Name: ______________ MI: ____ Last Name: ______________

Address: ______________________________

City: ____________ State: ____ Zip: ________ Date of Birth: ____________

SSN#: ______________________ Date Hired: ____________

Email: ______________________ Gender: ____

EMPLOYEE DEPENDENT INFORMATION

First and Last Name:	Gender:	SSN#:	Date of Birth:

Coverage Selections

☐ Plan Selection: ______________

Coverage Type:

☐ Employee Only ☐ Employee + Spouse

☐ Employee +Child(ren) ☐ Family

I understand that if I decline medical coverage, I will be unable to enroll in benefits until the next open enrollment period or due to a qualifying event.

☐ Decline Coverage Reason: ______________________

Employee Signature: ______________________

Today's Date: ______________