Benefit Assistance Corporation
PO Box 950, Hurricane, WV 25526
Phone (304)562-1913 * Fax (304)562-1916

ENROLLMENT / CHANGE / TERMINATION FORM

(Complete or check all that apply)

Group Name	Division/Department Number	Effective Date of Coverage or Change
WV Association of Counties	O33 Jackson County	

EMPLOYER

Reason For Completion: ☐ Enrollment ☐ Change in Coverage ☐ Termination ☐ Re-enrollment ☐ Beneficiary Change ☐ COBRA Start ☐ COBRA Stop

Changes:
- ☐ Change Name
- ☐ Change Address
- ☐ Change Coverage
- ☐ Loss / Acquisition of Spouse's Group Coverage
- ☐ Other - Specify _____
- Date of Above Event _____

Dependent Changes:
- Add Dependents due to:
- ☐ Marriage ☐ Birth ☐ Adoption
- ☐ Step-child ☐ QMCSO ☐ Other _____
- Drop Dependents due to:
- ☐ Divorce ☐ Death ☐ Other _____
- Date of Above Event _____

Cancel Coverage Due To:
- ☐ Termination of Employment (Other than gross misconduct)
- ☐ Reduction of Hours / Layoff
- ☐ Voluntary Termination of Coverage / Other Coverage
- ☐ Death
- ☐ Other - Specify _____
- Date of Above Event _____

_____
Authorized Employer Representative Signature

LEVEL OF BENEFITS APPLIED FOR

Dental/Vision

☐ Single $31.50 ☐ Family $82.00

EMPLOYEE

EMPLOYEE IDENTIFICATION

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth (Month / Day / Year)
			- -	/ /

Address	Telephone	Date of Hire (Month / Day / Year)
		/ /

City, State, Zip		Employed
		Jackson County Commission

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Employment Status: ☐ Active ☐ Retired ☐ COBRA

DEPENDENT INFORMATION

(Complete only if you have elected dependent coverage)

Legal Documentation (Court Decree, Guardianship Papers, Federal Income Tax Return, etc.) must be attached to this Application if relationship is Adoption, Step-Child, QMCSO or Other.

Relationship -(Spouse, Child, Step-child, Adoption, Other)	Name: First	MI	Last	Sex M / F	Date of Birth: Month	Day	Year	Social Security Number	Status Over Age 19: FT Student	Disabled
Spouse								- -		
								- -		
								- -		
								- -		
								- -		

Other Coverage: If you, your spouse and/or children are covered under another group plan, list participant name and name of health insurance provider below:

WAIVER OF COVERAGE

(Complete only if you wish to decline coverage)

I hereby decline coverage: ☐ for Myself ☐ for My Dependent Spouse ☐ for My Dependent Children ☐ for the Following Person(s) _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, eligibility will be subject to any eligibility requirements, special enrollment, open enrollment, late enrollment and other terms and provisions as specified in the group Plan Document.

EMPLOYEE ENROLLMENT / CHANGE AUTHORIZATION

I hereby apply for the coverage or changes to my existing coverage under the group benefit plan as indicated above. This application shall supercede any previous application as of the effective date indicated above.

_____ Date

_____ Employee Signature