Allstate BENEFITS

Employee Enrollment Form

EMPLOYER INFORMATION (must be completed)	
Company Name/DBA:	Company Address:

You must complete this form in its entirety in order for you or your dependents to be covered under the employer's group health plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)

BENEFIT PLAN:	GROUP NUMBER:

A - EMPLOYEE (Primary Applicant)

Legal Name: (Last)	(First)	(MI)

Social Security Number:	Gender: ☐ M ☐ F	Birth Date (mm/dd/yyyy):	**Average number of hours worked per week?**	**Date employed Full-Time: (mm/dd/yyyy)**

Home Street Address	City	State	Zip

Mailing Address (if different)	Mailing Address City	Mailing Address State	Mailing Address Zip

Home Phone:	Work Phone	Email Address:
Cell Phone:	Best Time to Call:	**Job Title**:

Status: ☐ Single ☐ Married Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner	Check One: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Cal-COBRA COBRA effective date(mm/dd/yyyy)	Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

NEW ENROLLMENT or WAIVER, please check one:

☐ New Hire ☐ Qualifying Life Event:_____Date: (mm/dd/yyyy) _____
☐ Re-hire ☐ COBRA
☐ Open Enrollment ☐ Waiver of Coverage (complete section B)
☐ New Group ☐ Other: _____

B - WAIVER OF COVERAGE – DO NOT COMPLETE IF ENROLLING FOR COVERAGE

Complete and sign if waiving any or all coverages for self. All eligible employees must be listed as either enrolling or waiving coverage when first eligible.

Indicate the waiver reason below.

☐ Individual Medical ☐ Medicare/Medicaid ☐ COBRA/Continuation ☐ Tricare ☐ Spouse's/Parent Employer Plan
☐ Cost/Do not want (NO health coverage will exist) ☐ Other: _____

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or Allstate Benefits. My dependents and I have waived such coverage of our own accord.

Signature:	Date:

Printed Name:	Date employed Full-Time: