PTX Services
Plymouth, WI

EMPLOYEE BENEFITS ENROLLMENT FORM

Last Name	First Name	MI	Date of Birth	
Address	**City**		**State**	**Zip Code**
Hire Date	**Marital Status**	**Home Phone**	**Social Security Number**	

GROUP MEDICAL (Check one)	EMPLOYEE ONLY	EMPLOYEE SPOUSE	EMPLOYEE CHILDREN	FAMILY
Prevea Health and Wellness Center	ENROLLED - COMPANY PAID			
Standard PPO				
Health Savings Plan (H S A qualified)				
Waive Coverage*		The plan only allows late enrollment in the event of loss of other coverage from a qualifying event.		
Optional Health Savings Account Contribution (per pay period)	$			

*Reason for Waiving Coverage - check one	Other Coverage		Covered by Medicare		I do not elect any coverage	

GROUP LIFE INSURANCE (enrollment form required)		
Basic Life	$10,000	ENROLLED - COMPANY PAID
Accidental Death & Dismemberment (AD&D)	$10,000	ENROLLED - COMPANY PAID

Optional Coverage:	WAIVE	$ 10,000	$ 20,000	$ 30,000	$ 40,000
Voluntary Life					
Voluntary AD & D					

OTHER OPTIONAL INSURANCE (enrollment form required)

	WAIVE*	ENROLL
Short Term Disability		
Long Term Disability		

*By waiving coverage, application for coverage at a later date may require further medical information or physical exam.

	WAIVE	EMPLOYEE ONLY	EMPLOYEE SPOUSE	EMPLOYEE CHILDREN	FAMILY
Dental Insurance					
Vision Insurance					

I have read and understand the benefit options provided by PTX Services, LLC. I authorize PTX Services, LLC to reduce my salary by the agreed upon amounts to pay premiums for the benefit elections I have made. I will report any change in my family status that may impact my insurance coverage to PTX Services, LLC within 31 days of the event.

EMPLOYEE SIGNATURE	DATE