

Product and Benefit Selection Form for Small Business



Group Name _____

Effective Date Requested _____

1. Single Option Medical Plan & Rx Selection. *Example 7AA w/2V* Plan _____ Rx _____
 Dual Option If taking Dual Option, please specify the two plans & Rx: _____ & _____
 Multi-Site List all other locations _____

1a. Are you enrolling in Health Savings Account (HSA)? Yes No

1b. Are you enrolling in a Health Reimbursement Account (HRA)? Yes No

- 1c. Deductible Administration
 Calendar Year (from Jan. 1 to Dec. 31)
 Policy or Contract Year (from effective date to renewal date)

2. Dental Plan Selection(s) 3a. Has this group been covered for major dental services for the previous 12 consecutive months?
 _____ Yes No If yes, name of carrier _____

3. Vision Plan Selection(s)

4. Supplemental Coverage(s)	Benefit Description
Life / AD&D <input type="radio"/> Yes <input type="radio"/> No	_____
Dependent Life <input type="radio"/> Yes <input type="radio"/> No	_____
STD <input type="radio"/> Yes <input type="radio"/> No	_____
LTD <input type="radio"/> Yes <input type="radio"/> No	_____

5. Optional Medical Rider(s)
- 24 Hour Coverage (At occupation coverage)
 - Infertility
 - Other (Please list)
- _____
- _____

6. Other Notes

Signature			
Employer Signature	Title	Date	