

**DUAL CHOICE
MEDICAL PLAN
SELECTION FORM**



PLAN SELECTION FORM

Group Name: _____

Group Number: _____

In order to enroll in your group health program, you must choose one of the following medical plans:

Class Number: _____ Plan Name: _____

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Employees elect their medical plan at the beginning of the plan year. They cannot change their election mid plan year. All covered members of a family will be enrolled on the same medical plan as the employee.

If you do not return this form during the enrollment period, it may result in enrollment delays.

Employee Name (please print)

Social Security Number

Employee Signature

Employee E-mail Address

Date