Daily Equipment Company

Employee Benefits Plan

ELECTION MENU and CHANGE FORM

		LOCATION	
EMPLOYEE LAST NAME	FIRST NAME	INTITIAL	SOCIAL SECURITY NUMBER
MAILING ADDRESS		PHONE NUMBER: HOME: CELL:	
CITY	STATE	ZIP	

DATE OF BIRTH	SEX	DATE OF HIRE	EFFECTIVE DATE	DO YOU HAVE OTHER COVERAGE? OTHER COVERAGE INFORMATION *EFFECTIVE DATE* & Group Name, Medicare A, B, D, or Medicaid (Please attach a copy of your or your dependent's ID card)

☐ Medical & Prescription Drugs		☐ Waive Coverage	☐ Dental		☐ Waive Coverage
☐ Employee Only	☐ Employee + 1	☐ Employee + Family	☐ Employee Only	☐ Employee + 1	☐ Employee + Family

LIST SPOUSE AND DEPENDENTS TO BE COVERED or DROPPED

		LAST NAME	FIRST NAME	MI	SSN	SEX	DATE OF BIRTH	ADD / DROP Please select type of coverage for each member (Medical / Dental)	DO YOU HAVE OTHER COVERAGE? OTHER COVERAGE INFORMATION *EFFECTIVE DATE* & Group Name, Medicare A, B, D, or Medicaid (Please attach a copy of your or your dependent's ID card)
1	SPOUSE							☐ Med ☐ Dnt ☐ Add ☐ Add ☐ Drop ☐ Drop	
2	CHILD							☐ Med ☐ Dnt ☐ Add ☐ Add ☐ Drop ☐ Drop	
3	CHILD							☐ Med ☐ Dnt ☐ Add ☐ Add ☐ Drop ☐ Drop	
4	CHILD							☐ Med ☐ Dnt ☐ Add ☐ Add ☐ Drop ☐ Drop	
5	CHILD							☐ Med ☐ Dnt ☐ Add ☐ Add ☐ Drop ☐ Drop	

IMPORTANT: PLEASE READ

1) If you are enrolling yourself or a dependent and you or they had medical coverage prior to enrolling in Daily Equipment Company's plan(s) please provide a copy of your Creditable Coverage Certificate from the medical plan that is termed or terming to Wanda Smith in Home Office.

   Without this certificate, payment of your medical claims will be delayed.

2) If you are enrolling a child between the age of 19 and 26, you must provide Daily Equipment Company with a copy of his/her **"birth certificate"**.

3) Any child between the ages of 19 and 26 that has access to other to other employer-sponsored group medical coverage offered by the employer of the child or of the child's spouse is NOT eligible for the Daily Equipment Company Plan.

I have reviewed the premiums for Medical and/or Dental coverage and authorize Daily Equipment Company to commence payroll deductions based upon my elections.

Employee Signature:______________________________ Date: ______________________

I have read and understand the Notice of Enrollment rights on the reverse side of this form.

Employee Signature:______________________________ Date: ______________________