New Hire/Newly Eligible Enrollment Form

Complete this form and submit it with required documentation to the Benefits Department at HRProc@Parkview.com .
This form confirms your recent benefit elections. I understand that I cannot change or revoke this election during the Plan Year unless I have a qualifying change in status or life event that permits such a change or revocation. If an error has been made in recording your elections, please contact HR at hrproc@parkview.com. Please keep a copy of this form for your records.
"I attested that my spouse either (1) is not currently eligible for medical plan coverage through an employer (not considered eligible coverage if coverage is through COBRA) or (2) is eligible for such medical plan coverage but the employer charges 100% of the cost of the plan (i.e., 100% of the premium) to my spouse".

1. Coworker Information

Full Name	Employee ID	Phone / Email
_____	_____	_____

2. Benefit Elections

Medical Plans		Dental Plans		Vision Plan
Select One: ☐ Parkview Focused Plan ☐ Parkview Expanded Plan ☐ Parkview High-Deductible Health Plan	☐ Co-worker ☐ Co-worker & 1 Child ☐ Co-worker & Spouse ☐ Co-worker & 2 or more children ☐ Family	**Select One:** ☐ Standard w/o Ortho ☐ Plus w/ Ortho	☐ Co-worker ☐ Co-worker & 1 Child ☐ Co-worker & Spouse ☐ Co-worker & 2 or more children ☐ Family	☐ Co-worker ☐ Co-worker & 1 Child ☐ Co-worker & Spouse ☐ Co-worker & 2 or more children ☐ Family

☐ FSA/HealthCare ☐ Annual amount $ _____ ☐ FSA/Dependent Care ☐ Annual amount $_____
☐ HSA ☐ Annual amount $_____ ☐ Limited Purpose FSA ☐ Annual amount $_____

3. Dependent Information (if applicable)

Relationship Codes **SP** = Spouse **C** = Child **SC** = Stepchild O = Other (specify)

Dependents To Be Covered (List spouse and/or eligible dependents to be covered. Use separate form for additional information.)

SSN	Name (First, M, Last)	* Relationship (See above Codes)	Date of Birth MM/DD/YY	Gender
	Spouse			☐ Male ☐ Female
	Dependent			☐ Male ☐ Female
	Dependent			☐ Male ☐ Female
	Dependent			☐ Male ☐ Female
	Dependent			☐ Male ☐ Female
	Dependent			☐ Male ☐ Female

4. Additional Voluntary Benefits – refer to Benefits Guide for coverage options

☐ Supplemental Employee Life Amount: $_____	☐ Supplemental Spouse Life Amount $_____
☐ Dependent Life Child Amount: $_____	☐ Supplemental Employee AD&D Amount: $_____
☐ Critical Illness Amount: $_____	
☐ Accident Insurance ☐ Co-worker ☐ Co-worker & Spouse ☐ Co-worker & Child(ren) ☐ Family	☐ Hospital Indemnity ☐ Co-worker ☐ Co-worker & Spouse ☐ Co-worker & Child(ren) ☐ Family

5. Coworker Certification

I understand that supporting documentation may be required and that benefit changes are subject to applicable plan rules and deadlines. **Return the completed form to hrproc@parkview.com.**

Coworker Signature	Date
_____	_____