

GUARDIAN ANGEL STAFFING AGENCY, INC.

HEALTH INSURANCE ELECTION FORM

CIRCLE YOUR SELECTION FOR EACH PLAN BELOW OR INDICATE YOUR DESIRE TO WAIVE

ANTHEM MEDICAL INSURANCE	
	MEDICAL WEEKLY PREMIUMS (52 Pays)
Single	
Employee/Spouse	
Employee/Child(ren)	
Family	
Waive Medical (please initial)	_____
DELTA DENTAL INSURANCE	
	DENTAL WEEKLY PREMIUMS (52 Pays)
Single	**$5.61**
Employee/Spouse	**$11.05**
Employee/Child(ren)	**$13.58**
Family	**$19.93**
Waive Medical (please initial)	_____
DELTA VISION INSURANCE	
	VISION WEEKLY PREMIUMS (52 Pays)
Single	**$1.45**
Employee/Spouse	**$2.90**
Employee/Child(ren)	**$3.11**
Family	**$4.97**
Waive Medical (please initial)	_____

RETURN ALL PAPERWORK TO: GUARDIAN ANGEL STAFFING 2821 S. HURSTBOURNE PARKWAY # 6 LOUISVILLE, KY 40220



Please provide details for dependents to be covered for the plans below								
	Name	Gender M or F	Date of Birth	Social Security	Address if different	Medical Y or N	Dental Y or N	Vision Y or N
Spouse								
Child								
Child								
Child								
Child								
Child								

COLONIAL Voluntary Products

	Benefit Amount	Weekly Premium
Voluntary Critical Illness		
Employee		
Employee/Spouse		
One-Parent Family		
Two-Parent Family		
Voluntary Accident		
Employee		
Employee/Spouse		
One-Parent Family		
Two-Parent Family		
Voluntary Short-Term Disability		

I elect to waive the Voluntary Critical Illness (initals) _____ Waive Accident _____

I elect to waive the Voluntary Short-Term Disability (initials)_____

I understand that once I make these elections, I cannot change them until December 1, 2027, unless I experience a valid qualifying event. Qualifying events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, or change in spouse's benefits or employment status. I must request all changes within 30 days of one of these events. Before the beginning of each plan renewal year, I will be offered the opportunity to change my election. I understand all eligible benefit deductions will be done on a pre-tax basis unless I request otherwise in writing.

_____ _____

Print Name Social Security Number

_____ _____

Signature Date

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