

**2026-2027 Plan Year
Enrollment/Change Form**



Last Name: _____

First Name, M.I.: _____

DOB: ____ / ____ / ____

1. HEALTH INSURANCE: Aetna Meritain

Plan Type

- Standard POS Plan
- HDHP Plan

Plan Coverage

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family

Non-Smoker Discount

- I am eligible for the non-smoker discount
- I am not eligible for the non-smoker discount

First Name/ Middle Initial	Last Name (if it differs from employee's)	Relationship to Employee	Birth Date	Gender	Social Security #*/ Medicare (HIC) <i>Medicare Enrollees, include a copy of your ID card and state reason for entitlement.</i>

****Note: Effective May 1, 2016, spouses who have health insurance available to them through their own employers are not eligible for coverage under the Archer & Greiner health insurance policy. Dependent children are eligible up to the age of 26 years-old regardless of student status.***

- I am waving coverage medical/prescription coverage. Please complete the Health Insurance Waiver.

2. DENTAL INSURANCE: Delta Dental

Please select the type of change you are making:

- Enrolling in coverage
- Terminating coverage
- Changing Plan Type, Plan Coverage and/or dependents

Plan Type

- Low Option
- High Option
- Enhanced Option

Plan Coverage

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family

First Name/ Middle Initial	Last Name (if it differs from employee's)	Relationship to Employee	Birth Date	Sex	Social Security #*

****Note: Effective January 1, 2017, dependent children are eligible up to the age of 26 years-old regardless of student status. Dependent children must reside with the employee and be fully supported by the employee.***

3. VISION INSURANCE: National Vision Administrators

Please select the type of change you are making:

- Enrolling in coverage
- Terminating coverage
- Changing Plan Coverage and/or dependents

Plan Coverage

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family

First Name/ Middle Initial	Last Name (if it differs from employee's)	Relationship to Employee	Birth Date	Sex	Social Security #*

****Note: Dependent children are eligible up to the age of 26 years-old regardless of student status.***

SIGNATURE

DATE

To be completed by the Benefits Department

Date Received

Initials