MedPlus
www.medplusplan.com

ENROLLMENT ACKNOWLEDGEMENT FORM

Employer Name: _____

Employee Information:

_____
Last Name First Name MI

_____
SSN DOB Gender

Employee Address:

_____
Home Street Address

_____
City State Zip

Phone: _____ Email: _____

ACTIVE EMPLOYEE
Monthly Premiums

	Employee	Employer
☐ Employee Only	$0.00	$44.68
☐ Employee + Spouse	$0.00	$98.28
☐ Employee + Child(ren)	$0.00	$82.64
☐ Employee + Family	$0.00	$136.24

RETIREE
Monthly Premiums

	Retiree	Employer
☐ Retiree Only	$0.00	$44.68
☐ Retiree + Spouse	$0.00	$98.28
☐ Retiree + Child(ren)	$0.00	$82.64
☐ Retiree + Family	$0.00	$136.24

Dependent Information:

Print full legal name (Last, First, MI)	Relationship	Gender	DOB

I hereby acknowledge that I am enrolling in the Pelican HRA 1000 + MedPlus GAP Plan Coverage

Effective Date of Coverage: _____

Employee Signature: _____ **Date**: _____