HPS Mechanical Benefits Enrollment Form

Effective Date: _____

Employee Information:

First Name	Last Name	M.I.

Address	Pay Period Type

Marital Status	Social Security Number	Phone #	Date of Birth	Date of Hire

Benefit Elections:

Medical

	Enrollment Status		
☐ **Kaiser Traditional $30/500**	☐ **Employee Only**	$	☐ **DECLINE Medical**
☐ **United Healthcare HMO $25-35/150 (AUI)**	☐ **Employee & Spouse**	$	
☐ **United Healthcare PPO Select Plus $30/1000/80%**	☐ **Employee & Child(ren)**	$	
	☐ **Employee & Family**	$	

Dental

GUARDIAN®

	Enrollment Status		
☐ **Plan 1 HMO Dental**	☐ **Employee Only**	$	☐ **DECLINE Dental**
☐ **Plan 2 PPO Dental**	☐ **Employee & Spouse**	$	
Employee Contributions are indicated on reverse side of form	☐ **Employee & Child(ren)**	$	
	☐ **Employee & Full Family**	$	

Vision

Superior Vision

	Enrollment Status		
☐ **SuperiorVision $10/25/25**	☐ **Employee Only**	$	☐ **DECLINE Vision**
	☐ **Employee & Spouse**	$	
Employee Contributions are indicated on reverse side of form	☐ **Employee & Child(ren)**	$	
	☐ **Employee & Family**	$	

Life

UnitedHealthcare®

Note: HPS Mechanical pays Employee only Life AD&D $25,000 rate	**Employer Paid**	Employer Paid EE only

Beneficiary Information for GI Life Insurance

				Percentage
Name		Relation		
Address		Age		
Name		Relation		
Address		Age		
		Percentage must equal 100%		

Employee Pay Period Total:

My signature indicates that I have read the descriptive material provided and understand the options available to me. I have indicated the elections above and authorize my employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll amount is subject to change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan Year and may be changed ONLY at the annual enrollment period listed above or within 30 days of a qualifying event or change in family status.

_____

_____

Employee Signature Date