M Holland Benefit Elections

EMPLOYEE INFORMATION:

Employee First Name _____ Employee Last Name:_____

Employee Date of Birth: _____ Employee SSN: _____

Employee Address:_____ City: _____

State:_____ ZIP Code:_____

Employee Gender: _____ Employee Phone Number:_____

Employee Email Address: _____

Employee PCP Full Name: _____ Employee PCP Town: _____

Hire Date: _____ Salary/Hourly Rate: _____

DEPENDENT INFORMATION:

Spouse:

First Name: _____ Last Name: _____ DOB:_____

SSN: _____ Gender: _____PCP Full Name: _____

Spouse Address (If different):_____

Dependent 1

First Name: _____ Last Name: _____ DOB:_____

SSN: _____ Gender: _____PCP Full Name: _____

PCP Town:_____

Dependent 2

First Name: _____ Last Name: _____ DOB:_____

SSN: _____ Gender: _____PCP Full Name: _____

PCP Town:_____

Dependent 3

First Name: _____ Last Name: _____ DOB:_____

SSN: _____ Gender: _____PCP Full Name: _____

PCP Town:_____

Dependent 4

First Name: _____ Last Name: _____ DOB:_____

SSN: _____ Gender: _____PCP Full Name: _____

PCP Town:_____

M Holland Benefits Elections:

BCBS of MA Medical (Check One): Enroll: ☐ Waive: ☐

Tier (Check One): Employee ☐ Family: ☐

BCBS of MA Dental (Check One): Enroll: ☐ Waive: ☐

Tier (Check One): Employee ☐ Family: ☐

Life Insurance (Company Paid): Enroll: ☒

Long Term Disability (Company Paid): Enroll: ☒

Signature: _____ Date: _____