2020/2021 ENROLLMENT FORM

Coverage eff _____

Name:	SSN:	Email:

Medical coverage	If enrolling, circle the plan you wish			CORE Plan	CORE PLUS Plan
	WAIVE COVERAGE	Individual	My child(ren) and me	My spouse and me	My and family me
Health Savings Account	WAIVE DEDUCTION	Deduct _____ biweekly			
Dental	WAIVE COVERAGE	Individual	My child(ren) and me	My spouse and me	My and family me
Vision	WAIVE COVERAGE	Individual	My child(ren) and me	My spouse and me	My and family me
Basic Life	CMH Provided, automatically enrolled				
Supp Life	WAIVE COVERAGE	1x supp	2x supp	3x supp	4x supp
Dependent Life	If enrolling, circle the plan you wish	$5k spouse, $2k/child	$10k spouse, $5k/child	$20k spouse, $10k/ child	$50k spouse, $10k/ child
	WAIVE COVERAGE	Cover child(ren) only	Cover spouse only	Cover and Spouse children	
Basic LTD	CMH Provided, automatically enrolled				
Supp 10% LTD	WAIVE COVERAGE	Yes, I want			
Dep. Care Spending	WAIVE DEDUCTION	Deduct _____ biweekly			

Name of covered family member	DOB?	SS number	Med?	Dent?	Vision?	Dep Life?

Beneficiary on your life insurance. If left blank, current beneficiaries will remain in effect.

Name of beneficiary	Relationship	Primary Percent	Primary percent	Contingent	Percent

I authorize the elections I have made above and the deductions required for those elections.

Your signature	Date

Enrollment questions and completed forms should be emailed to hrbenefits@cmhc.org
Form can be faxed to 207.795.2385 or mailed to HR office, CMH, PO Box 4500, Lewiston, ME 04243

If possible, please keep a copy for your records.