Arena Technical Resources, LLC

Employee Medical and Dental Enrollment/Waiver Form

Please print clearly in CAPITAL letters ***Please fill in completely*** ***Please sign the form***

○ New Subscriber ○ Member adding line of coverage ○ Subscriber adding dependent ○ **WAIVER**

EMPLOYEE SIGNATURE for WAIVER ________________________________ **DATE** ____/____/____

EMPLOYEE ENROLLMENT INFORMATION

Last Name	First Name	MI	Name Suffix (Jr., III)

Street Number	Street Name	Apartment #

City	State	Zip Code	Email Address

Social Security Number	Date of Birth (MM-DD-YY)	Gender	Marital Status
		M ☐ F ☐	Single ☐ Married ☐

Home Phone Number	Full-time Hire Date (MM-DD-YY)	Requested Effective Date (MM-DD-YY)

DEPENDENT ENROLLMENT INFORMATION

Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Gender	>18 & F/T Student Y/N	Disabled Y/N	Dependent Elections		***Required for POS or HMO plans*** Primary Care Physician & OB/GYN		Existing Patient?
									Physician Name	Carefirst Phy. #	Y/N
	Self						MEDI	DENT			

PLAN ENROLLMENT/WAIVER INFORMATION

Medical	Plan Selection ☐ HMO ☐ POS ☐ PPO	Tier Selection ☐ Individual ☐ Individual & Child(ren) ☐ Individual & Spouse ☐ Family ☐ Waive Coverage
Dental	Traditional Dental Plan only	Tier Selection ☐ Individual ☐ Individual & Child(ren) ☐ Individual & Spouse ☐ Family ☐ Waive Coverage

EMPLOYEE ENROLLMENT SIGNATURE and BENEFICIARY ASSIGNMENT

Primary Beneficiary ________________________________ Relationship ________________

Secondary Beneficiary ________________________________ Relationship ________________

EMPLOYEE SIGNATURE for ENROLLMENT ________________________________ **DATE** ____/____/____