Foremost/Stockmeister Group
2024 Enrollment Form

Name (First, MI, Last)	Employee SSN	Company
Home/Mailing Address (please include street, city, state, zip)	Employee Date of Birth	Date of Hire
Contact Info: Phone/Email		
This is a: ☐ NEW ENROLLMENT ☐ CHANGE of ENROLLMENT ☐ OPEN ENROLLMENT/REENROLLMENT		

Dependents: *(Please only list dependents that you wish to cover under one or more of the noted/selected benefits.)*

Relationship Code**	Name (First, MI, Last)	Social Security Number	Date of Birth	Gender M or F	Coverage Elections	Change
					☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life	☐ Add ☐ Drop
					☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life	☐ Add ☐ Drop
					☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life	☐ Add ☐ Drop
					☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life	☐ Add ☐ Drop
					☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life	☐ Add ☐ Drop

**Relationship Code: SP=Spouse CH=Child CO=Court Ordered Dependent

2024-2025 Plan Elections

***Please mark an election in EACH coverage below*:**

Coverage/Plan Selection	Tier Election
Medical ☐ Enroll – Anthem/MMP Gap ☐ Include MetLife BASIC LIFE ($20,000)	☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + Family ☐ Decline/Waive
Voluntary Dental – MetLife ☐ **Enroll Dental**	☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + Family ☐ ☐ Decline/Waive
Voluntary Vision - MetLife ☐ **Enroll Vision**	☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + Family ☐ Decline/Waive
Voluntary Life - Employee **Voluntary Life -** Spouse **Voluntary Life** - Child(ren)	☐ Add ☐ Increase New Amount: $_____ ☐ Cancel ☐ Add ☐ Increase New Amount: $_____ ☐ Cancel ☐ Add ☐ Increase New Amount: $_____ ☐ Cancel

Please complete reverse side! 

Beneficiary – Employees MUST complete for Employer Provided Basic Life/AD&D and Voluntary Life Coverage:

Primary Beneficiary Name	Address	Date of Birth	Relationship	Benefit %
Contingent Beneficiary Name	**Address**	**Date of Birth**	**Relationship**	**Benefit %**

Waiver/Declination of Coverage: Complete this Section ONLY if you are NOT enrolling for any coverage(s):

Reason for decline/waiver of coverage:

□ Spouse's Employer Plan □ Other*

□ Covered by Medicare/Medicaid *State Reason: _____

I understand that by waiving coverage at this time, I will NOT be enrolled in any of the offered coverages. I understand that I will not be allowed to participate unless I experience a qualified life event, enroll during the next Open Enrollment period or as a late enrollee, if applicable.

Employee Signature Required for Waiver: _____ Date: _____

Section 125 Cafeteria Premium Only Plan Section

Pre-Tax Premium Elections	
Coverage	Per Paycheck Premium
Medical	$
Dental	$
Total to withheld pre-tax each paycheck	$

AFTER-Tax Premium Elections	
Coverage	Per Paycheck Premium
Voluntary Life - Employee	$
Voluntary Life - Spouse	$
Voluntary Life – Child(ren)	$
Total to withheld AFTER Tax each paycheck	$

AUTHORIZATION AND REQUEST FOR COVERAGE

I hereby request to enroll in the Benefit Plan for which I am or may become eligible under the plan created by the above Plan Sponsor; (2) affirm that I will abide by the provisions set forth in the Summary Plan Description and Plan Document; (3) designate the beneficiary named by me to receive the benefits, if any, payable in the event of my death and (4) certify the above information to be true and correct to the best of my knowledge and that dependents listed above are my legal dependents.

I further understand that I may not revoke or change my participation in this plan until the next plan anniversary unless I experience a change in my family status or a change in my or my spouse's employment status. I also authorize the payroll reductions noted above.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

_____ _____ _____ _____

Applicant Signature Date Insurance Administrator Signature Date