

# EMPLOYEE INSURANCE AUTHORIZATION FORM



**Employee Name:** \_\_\_\_\_

**Employee ID #:** \_\_\_\_\_

**Department:** \_\_\_\_\_

(Please check one option)

## **Medical Insurance**

_____	HMO Select	Employee Only	_____
_____	HMO Premier	Spouse	_____
_____	NPOS	Children	_____
_____	Vision	Family	_____

## **Dental Insurance**

_____	Pre-Paid (DHMO)	Employee Only	_____
_____	PPO	Spouse	_____
		Children	_____
		Family	_____

Coverage: \_\_\_\_\_ Added \_\_\_\_\_ Changed, or \_\_\_\_\_ Cancelled

**Effective Date:** \_\_\_\_\_

**Bi-Monthly Premium:** \_\_\_\_\_ (Medical)  
\_\_\_\_\_ (Dental)  
\_\_\_\_\_ (Vision)

Remarks : \_\_\_\_\_  
\_\_\_\_\_

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_