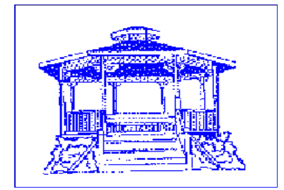
City of Pass Christian



Employee Name (last,first)		SS#		DOB		Gender	
Address		City		State		Zip	
Hire Date		Marital Status		Phone			
Enrollment Reason		e-mail address		Occupation			

******CHECK BOX BESIDE DESIRED COVERAGE OPTIONS BELOW******

Medical coverage (bi-Monthly cost)

- Employee Only □ $0.00
- Employee/Spouse □ $346.72
- Employee/Child(ren) □ $267.92
- Family □ $661.92

Decline □

Are you covered by any other insurance? Yes □ No □

If yes, type ____

Medicare A or B? Yes □ No □

Dependent Name	SS#	Gender	DOB	Relation

Vision Coverage (bi-Monthly Cost)

- Employee Only □ $3.98
- Employee + 1 Dependent □ $6.95
- Family □ $11.71

Decline □

Dependent Name	SS#	Gender	DOB	Relationship

Dental Coverage (bi-Monthly Cost)

- Employee Only □ $14.61
- Employee/Spouse □ $30.61
- Employee/Child(ren) □ $32.09
- Family □ $51.32

Decline □

Dependent Name	SS#	Gender	DOB	Relationship

Life/AD&D - $15,000
City Of Pass Christian Covers the cost

Beneficiary name	Gender	DOB	Relation	Benefit %

Signature ____ ***Date*** ____