Anderson Funeral Home

Benefit Election Form

Applicant Information

Full Name: ______________________________ Date of Hire: __________

Last *First* *M.I.*

Address: ______________________________

Street Address or PO Box *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ______________ Email ______________

Date of Birth: __________ Social Security No.: __________ Annual Salary: **$** __________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Do you use tobacco? ☐ Yes ☐ No

Dependents

Social Security #	Type	Last Name	First Name	Sex	Date of Birth	Use Tobacco?
	Spouse					☐ **Yes** ☐ **No**
	Dependent (A)					☐ **Yes** ☐ **No**
	Dependent (B)					☐ **Yes** ☐ **No**
	Dependent (C)					☐ **Yes** ☐ **No**
	Dependent (D)					☐ **Yes** ☐ **No**
	Dependent (E)					☐ **Yes** ☐ **No**

Coverage

Core Benefit ELECTION	OPTION	COVERAGE LEVEL			
HEALTH BCBS of SC		Employee Only	Employee & Spouse	Employee & Children	Employee & Family
☐ Enroll ☐ Change ☐ Waive	☐ PPO	☐ $ 0.00	☐ $	☐ $	☐ $
BASIC LIFE BCBS of SC		Employee Only	* Basic life is provide to all full time employees		
☒ Enroll	☒ 10,000	☒ $ 0.00			
DENTAL BCBS of SC		Employee Only	Employee & Spouse	Employee & Children	Employee & Family
☐ Enroll ☐ Change ☐ Waive	☐ PPO	☐ $ 0.00	☐ $	☐ $	☐ $
VISON VSP		Employee Only	Employee & Spouse	Employee & Children	Employee & Family
☐ Enroll ☐ Change ☐ Waive	☐ PPO	☐ $ 0.00	☐ $	☐ $	☐ $

Allstate Benefit ELECTION	OPTION	COVERAGE LEVEL / Bi-Weekly Premium			
UNIVERSAL LIFE Allstate Benefits		Death Benefit	Premium Per Pay		
☐ Enroll ☐ Change ☐ Waive	☐ Employee ☐ EE & Children ☐ Spouse	$ $ $	$ $ $		
DISABILITY Allstate Benefits		Monthly Benefit	Premium Per Pay		
☐ Enroll ☐ Change ☐ Waive	☐ Basic ☐ Enhanced	$	$		
ACCIDENT Silver Plan Allstate Benefits		Employee Only	Employee & Family		
☐ Enroll ☐ Change ☐ Waive	☐ Low ☐ High	☐ $ 6.03 ☐ $ 9.83	☐ $ 11.16 ☐ $ 14.95		
CANCER Allstate Benefits		Employee Only	EO with ICU	Employee & Family	FA with ICU
☐ Enroll ☐ Change ☐ Waive	☐ Basic ☐ Enhanced ☐ Premier	☐ $ 4.21 ☐ $ 6.11 ☐ $ 7.47	☐ $ 5.59 ☐ $ 7.49 ☐ $ 8.85	☐ $ 7.25 ☐ $ 10.86 ☐ $ 13.53	☐ $ 10.02 ☐ $ 13.62 ☐ $ 16.30
CRITICAL ILLNESS Allstate Benefits		Employee Only	Employee & Children	Employee & Family	
☐ Enroll ☐ Change ☐ Waive	☐ 10,000 ☐ 20,000	☐ $ ☐ $	☐ $ ☐ $	☐ $ ☐ $	

Beneficiary

Life Insurance Beneficiary's Full Name	Relationship

Disclaimer and Signature

REPRESENTATION *I represent that all information supplied in this* ***ELECTION FORM*** *is true, and correct.* ***PREMIUM DEDUCTION AUTHORIZATION*** *I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.* ***UNDERSTANDING*** *I understand this election form does not bind coverage and that a formal electronic application will be submitted to the carrier(s) for the coverage requested. If Evidence of Insurability (EOI) is required you will be contacted for additional information.*

Employee Signature: ______________________________ Date: ______________

Administrator Signature: ______________________________ Date: ______________

Return Election Form To

MAIL	OVERNIGHT	FAX	EMAIL
Workplace Benefits Plus PO Box 1148 Beaufort, SC 29901	Workplace Benefits Plus 14 Flycatcher Lane Beaufort, SC 29907	(866) 884-6076	mprescott@WorkplaceBenefitsPlus.com

Have Questions?
Contact Mitchell Prescott with Workplace Benefits Plus at (843) 522-3835