MEC PLAN SUBSCRIBER APPLICATION

EMPLOYER

EMPLOYEE INFORMATION

NAME

SOCIAL SECURITY NUMBER

M / F
DATE OF BIRTH GENDER

STREET ADDRESS

CITY STATE ZIP

HOME PHONE

EMAIL ADDRESS

BENEFIT SELECTION: MEC BASIC

Employee only: ❍ YES ❍ NO

Employee and family: ❍ YES ❍ NO

Total # enrolled: ____________________

Waving benefits due to: ❍ OTHER COVERAGE

❍ OTHER REASON

REQUIRED DEPENDENT INFORMATION

NAME

SOCIAL SECURITY NUMBER

M / F
DATE OF BIRTH GENDER

CHILD:
Marriage and birth certificates are required for all dependents.

NAME

SOCIAL SECURITY NUMBER

M / F
DATE OF BIRTH GENDER

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SIGNATURE

I understand by signing below, I am enrolling in the benefit(s) selected or waiving health insurance coverage.

SIGNATURE DATE

Signed form must be received within 30 days of requested effective date.

REV. 8/2/16

For questions or to submit form: email enrollment@setseg.org or fax (517) 492-0872