BENEFITS ENROLLMENT FORM

Noramtec Consultants Americas Inc.

SECTION 1 - EMPLOYEE INFORMATION

Name (Last, First, MI):

Gender: Male Female	DOB (MM/DD/YY) / /	SS#: - -
Address:		
City: State: Zip:	Daytime Phone:	
Hire Date: / /	Eligibility Effective Date: / /	
Email address:		

SECTION 2 – COVERAGE ELECTIONS OR WAIVER OF COVERAGE

	Single	EE+SP or MEC Single+1	EE+Children or MEC Single+2	Family or MEC Single+ 3+
MEC Option 1 (Preventative Care Only)				
MEC Option 2 (With Limited Medical Benefits)				
Option 3 Excellus Signature High Deductible				
Option 4 Excellus Signature Copay				
Guardian Dental				
Guardian Vision Please choose 1 Option (VSP or Davis Vision)				

COVERAGES DECLINED (circle)

Medical Dental Vision

I have elected not to apply for coverage at this time for myself or my dependents (if any). I have coverage from: (circle one)
Medicare Medicaid Spouse Plan Parent Plan Military Plan
List current carrier and ID number-

I understand that if I waive this coverage and do not have valid coverage in another plan, in accordance with IRS rules, I must pay a fee. The fee is called the individual shared responsibility payment. The fee is sometimes called the "penalty," "fine," or "individual mandate."
Note : You will not be a ble to en roll until the next open enrollm ent or if you have a Qualified Event.

SECTION 3 DEPENDENT INFORMATION

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

SECTION 4 - EMPLOYEE SIGNATURE

X Date:

I understand I may not drop my coverage unless there is a Qualifying Event (QE) or the Plan has an Open Enrollment period. Changes must be submitted within 30 days of Qualifying Event