Location: _____	Job Title: _____	Effective Date:

Suwannee Medical Personnel
Enrollment Form

Name: _____	Birth Date: _____Hire Date:_____

Gender: ___SSN: _____Mobile Phone # _____Children: Y N

Spouse Name: _____Spouse Birth Date:_____ SS# _____

Home Address: _____

City: _____	State: _____	ZIP: _____

Child: _____Gender:___ Birth: _____SS# _____

Child: _____- Gender:___ Birth: _____SS# _____

Beneficiary:_____Relationship:_____Birth Date:_____

Accident: Plan 1 _____ Plan 2 _____ Employee Only: _____ EE Children: _____ Employee Spouse: _____ Family: _____	Supplemental Health: Plan 1____Plan 2____ (SHOP) Employee Only: _____ EE Children: _____ Employee Spouse: _____ Family: _____
Cancer: Plan 1 _____ Plan 2 _____ Employee Only: _____ EE Children: _____ Employee Spouse: _____ Family:_____	Critical Illness: Plan 1 _____ Plan 2 _____ Employee Only: _____ EE Children :_____ Employee Spouse: _____ Family: _____

Short Term Disability: _____ Gross Monthly Income: $_____
Average Hours Worked Per Week _____
Monthly Benefit Amount: $_____
Elimination Period: 0/7_____ 14/14_____ Benefit Period: 3 Months _____ 6 Months _____

Term 100 Life Insurance:
Employee: _____
Spouse: _____
Child: _____

Suwannee Medical Personnel strongly encourages everyone to talk with an enrollment specialist by phone to have a full understanding of provided benefits.

Please complete this form, and email or fax it in. Then contact Best Worksite Benefits at: (904) 257-8800 Ext. 110. You will need to talk with a benefit specialist by phone once the form is sent in to complete your enrollment.

Email: admin@bestworksitebenefits.com
Fax: (904) 677-7911

Signature: _____Date:_____