



RETURN FORM TO:

membership@mid-americanbenefits.com or

Fax: 402-573-8058

EMPLOYER: _____

EMPLOYEE NAME: _____ ID #: _____

EMPLOYEE EMAIL ADDRESS AND MOBILE PHONE NUMBER: _____

LATE / OPEN
 SPECIAL ENROLLMENT REASON: _____

Effective Date: _____ Qualifying Event date: _____

ADD SPOUSE:
Coverage Desired: Medical/Rx Dental Vision Life/AD&D Dep Life STD LTD
NAME: _____ GENDER: M F
SOCIAL SECURITY #: _____
DATE OF BIRTH: _____ MARRIAGE DATE: _____

ADD CHILD(REN) DUE TO: MARRIAGE BIRTH ADOPTION COURT ORDER
Coverage Desired: Medical/Rx Dental Vision Life/AD&D Dep Life STD LTD
1.) NAME: _____ GENDER: M F
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
2.) NAME: _____ GENDER: M F
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
3.) NAME: _____ GENDER: M F
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

NAME CHANGE: Former Name: _____
New Name: _____
Reason for Name Change: _____
 ADDRESS CHANGE New Street, City, State, Zip Code

Effective Date: _____

CHANGE OF BENEFICIARY:
I hereby revoke any other beneficiary designation and optional method of settlement election and, in accordance with the terms and provisions of the group, designate the person(s) named as beneficiary.
FULL NAME: _____ RELATIONSHIP: _____ BIRTHDATE: _____ PERCENTAGE: _____
FULL NAME: _____ RELATIONSHIP: _____ BIRTHDATE: _____ PERCENTAGE: _____

YOUR APPROVAL

I hereby request my employer to arrange for benefits which I have elected. I authorize my employer to make the proper deductions (if any) from my earnings as my contribution toward the cost of this Plan. I verify that all the information on this form is correct.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

EMPLOYER SIGNATURE: _____ **DATE:** _____