

Kenyon College UMR Health/Dental Enrollment or Change Form



Enrollment selections on this most current form will supersede any previous enrollment selections.

Name: Last, First, M.I.

Start Date or Change Date

Home Phone

Home E-mail

Date of Birth

Last 4 digits of SSN

Gender

Marital
Status

Current Home Address (If you are in the process of moving, please provide your address at this time, then provide an update to HR once your new address is established). List Street Address, P.O. Box if applicable, City, State, Zip.

KC Health Insurance Plan - [Detailed Eligibility, Rates and Plan information](#)

Health Coverage Options if you have selected enrollment on the left

KC Dental Insurance Plan - [Detailed Eligibility, Rates and Plan information](#)

KC Vision Insurance Plan - [Detailed Eligibility, Rates and Plan information](#)

Waive Coverage

Premium Plan

Basic Plan

HDHP/HSA

Employee Only

Employee + 1

Family (3 or more)

Waive Coverage

Employee Only

Employee + 1

Family (3 or more)

Waive Coverage

Employee Only

Employee + 1

Family (3 or more)

**If you waive medical coverage, please add a brief decline reason above for ACA reporting.*

Add the names of the dependent(s)/spouse//partner you wish to enroll below:

Name (First, MI, Last)	Social Security #	Gender	Birth Date <input type="text"/>	Relation
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Name (First, MI, Last)	Social Security #	Gender	Birth Date <input type="text"/>	Relation
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Name (First, MI, Last)	Social Security #	Gender	Birth Date <input type="text"/>	Relation
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Name (First, MI, Last)	Social Security #	Gender	Birth Date <input type="text"/>	Relation
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Check this box if you or any of your dependents have other health or dental coverage that should be counted as primary.

Yes, I confirm that I have additional health or dental coverage and will provide insurance information to Human Resources

Signature

Date

If your software does not allow for signatures, please type your initials here in lieu of a signature.