

**WEA Select Medical Plan
ENROLLMENT / CHANGE APPLICATION**

Employee Name (Last) _____ (First) _____ (MI) _____			
Mailing Address (Street Address or PO Box) _____		City _____	State _____
Social Security No. _____		Date of Birth _____	Gender F M
Telephone Number _____		Email address the carrier can use to contact you _____	

Step 1: Select Plan

Step 2: Select Insurance Carrier (Aetna or UnitedHealthcare)

Step 3: Select Network (Preferred Provider Organization (PPO) or High Performance Network)

Aetna													
Plan 5		Plan 2		Plan 3		Easy Choice A		Easy Choice B		Basic Plan		QHDHP	
<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO
<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance
UnitedHealthcare													
Plan 5		Plan 2		Plan 3		Easy Choice A		Easy Choice B		Basic Plan		QHDHP	
<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO	<input type="checkbox"/>	PPO
<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance	<input type="checkbox"/>	High Performance

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Legal Spouse (Last, First, Middle Initial)	Social Security Number	Gender F M	
	Date of Birth	Add	Drop
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender F M	
	Date of Birth	Add	Drop
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender F M	
	Date of Birth	Add	Drop
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender F M	
	Date of Birth	Add	Drop
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender F M	
	Date of Birth	Add	Drop
Dependent Child (Last, First, Middle Initial)	Social Security Number	Gender F M	
	Date of Birth	Add	Drop
Employee Signature			
Office Use Only	Date of Hire	Effective Date of Insurance	