Legal Assistance Enrollment Form

EMPLOYEE INFORMATION

Last Name____ **First Name**______________________________ **Sex:** ☐ Male ☐ Female

Address ____ **City** ____________________________________ **State**_______ **Zip Code** _________

Date of Hire___________________________ **Benefits Eligibility Date** ________________________ **Date of Birth** ___________________________

ENROLLMENT/CHANGES: ☐ **New Enrollment** ☐ **Open Enrollment** **Effective Date:** ________/________/_______

Monthly Cost	☐ $18.00

CANCELLATION OF COVERAGE: ☐ **Open Enrollment** **Effective Date:** ________/________/_______

I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize the company to deduct from my pay on a post-tax basis and remit any required contribution for the cost of coverage. This authorization is to remain in effect until I notify the company in writing of any changes. I also understand that I cannot cancel my coverage until the next Open Enrollment period.

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Employee Signature **Date** **Human Resources Approval** **Date**