BENEFIT ENROLLMENT OR WAIVER FORM

Employee Name (Printed):	Date:

I wish to enroll or waive my enrollment in the following benefits. I have been given insurance booklets or an explanation of each benefit to make my decision.

Benefit	When Eligible	Enroll	Waive Enrollment
Health Insurance			
Dental			
Vision			
Life Insurance			
Pension / Retirement			
Long-Term Disability			
Credit Union			
EAP			
Membership in Associations, Clubs			
Other:			
Other:			
Other:			
NYS Disability	Upon Hire or after 4 Weeks*	Mandatory	
NYS Workers' Compensation	Upon Hire	Mandatory	
NYS Unemployment Insurance	Upon Hire	Mandatory	
Social Security	Upon Hire	Mandatory	

Employee Signature:	Date:
Company Representative:	Date:

*An employee who has changed jobs from one covered employer to another covered employer is eligible for NYS Disability upon hire. Otherwise, an employee is generally eligible for coverage after four consecutive weeks of employment.