●Medical ● Dental ● Vision ● Life/AD&D Enrollment / Change Request

Transamerican AUTO PARTS COMPANY

A. ACTION DESIRED

Enrollment – *Check one*

□ **New Enrollee** Date of Hire:_____ Effective Date:_____

□ **Rehire / Reinstatement** Date of Rehire / Reinstatement: _____

□ **Add/Delete Dependent(s)** Effective Date: _____

Change – *Check all that apply* **Date of Event:**_____

□ **Cancel Coverage for Self** □ **Delete Spouse** □ **Delete Child**
◇ Other Coverage ◇ Divorce ◇ Overage Dependent ◇ Reduction in Hours
◇ Medicare Eligible ◇ Open Enrollment

Change – *Check all that apply* **Date of Event:**_____

□ **Add Spouse** □ **Add Dependent Child** □ **Name Change** □ **Other**
◇ Marriage ◇ Birth ◇ Open Enrollment ◇ Court Order ◇ Eligibility Period

B. PERSONAL INFORMATION

Employee: Last Name	**First Name**	**Middle Initial**	**E-Mail:**	**SS #**

Residence Address:	**Apt #**	**City**	**State**	**Zip**	**Home Telephone #:** ( )	**Alternate Telephone #:** ( )

C. MEDICAL PLAN OPTION	**DENTAL PLAN OPTION**	**VISION PLAN OPTION**	**WF HSA Account (per pay period)**
□ **AETNA POS II (PPO)** □ **AETNA SELECT** □ **AETNA POS II (HSA)**	□ **AETNA Dental (DPPO)** □ **AETNA Dental (DHMO)**	□ **VSP** □ **VSP (Protec)** (Employee Only Coverage)	**Please deduct the following amount per payroll:** **$ .00** **Employee Max: $128.84** **Family Max: $255.76**

Please visit AETNA's website to search for a Doctor or Dentist at:
www.aetna.com/docfind

Please fax this form to (310) 667-9128 or call (310) 900-7722 for assistance

MEDICAL	Primary Care Physician ID #: (Only Required for Aetna Select)	DENTAL	Primary Care Dentist ID #: (Only Required for DHMO)	VISION	Last Name, First Name, Middle Initial	Gender	Social Security #	Relationship	Birth Date Month	Day	Year
□ Add □ Delete		□ Add □ Delete		□ Add □ Delete		□ M □ F	- -	SELF			
□ Add □ Delete		□ Add □ Delete		□ Add □ Delete		□ M □ F	- -	SPOUSE			
								Child(ren)			
□ Add □ Delete		□ Add □ Delete		□ Add □ Delete		□ M □ F	- -	Child			
□ Add □ Delete		□ Add □ Delete		□ Add □ Delete		□ M □ F	- -	Child			
□ Add □ Delete		□ Add □ Delete		□ Add □ Delete		□ M □ F	- -	Child			
□ Add □ Delete		□ Add □ Delete		□ Add □ Delete		□ M □ F	- -	Child			

To add additional children please use another Enrollment Form.

D. Life, AD&D & LTD Insurance
TAP Is paying the FULL cost for this coverage. You are automatically enrolled and covered under benefits upon eligibility date according to our plan documents.

Beneficiary Name	Beneficiary's Date of Birth	Relationship	%
1)			
2)			
3)			
4)			

E. Acknowledgements – Signature Required ONLY if electing Medical / Dental / Vision Coverage

I hereby request the group for which I am or may become eligible and authorize deductions from earnings to serve as payments for any required contributions. I agree that my compensation will be reduced by the amount necessary to cover the employee portion if the premium owed for my group health coverage.

My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge. I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being voided as of its effective date with no benefits payable.

Employee Signature: _____ **Date:** _____

F. WAIVER OF COVERAGE

Waiver applies to:

☐ **SELF** ☐ Medical ☐ Dental ☐ Vision ☐ **SPOUSE** ☐ Medical ☐ Dental ☐ Vision ☐ **CHILD(REN)** ☐ Medical ☐ Dental ☐ Vision

Reason for waiving coverage (Required only if employee is waiving coverage – Not required if waiving coverage for dependents)

□ Other Group Coverage Carrier Name:_____ / Group #: _____

□ Medicare □ Medi-Cal □ Individual Policy □ Other Reason: _____

Signature (REQUIRED if waiving Health / Medical Coverage)
I understand that by waiving coverage for myself and/or my dependents, I may not be eligible to participate in this plan during this plan year. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I furnish my Employer with a certificate of coverage termination and that I request enrollment within 30 days that the other coverage ends.

In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I furnish my employer with documents, such as a marriage certificate, birth certificate, adoption certificate and/or court documents and request enrollment within 30 days of the qualifying event.

Employee Signature: _____ **Date:** _____