

# Affirmative Election Form

**FAILURE TO COMPLETE & RETURN THIS FORM WILL RESULT IN A CHANGE TO YOUR BENEFITS**

Employer Name: **TOWNSHIP OF UNION BOARD OF EDUCATION**

## EMPLOYEE/PARTICIPANT INFORMATION

Please PRINT and fill this section out COMPLETELY

Social Security #:	Last Name:	First Name:	M.I.:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Address:		
City:	State:	Zip:	Home Phone #:	Work Phone #:
E-mail:	<b>Effective Date: 1/1/2021</b>			

I understand by signing this form, I choose to stay in my current plan for 1/1/2021. I also understand that I am not able to make any changes to my plan or plan section until the next open enrollment period, unless I have a qualifying life event.

If you experience a qualifying life event and need to make a change, please contact your personnel department, within 30 days of the event. Examples of a qualifying life event are the following:

- Marriage
- Birth or adoption of a child
- Loss or reduction of coverage for you or your spouse
- Death of a covered dependent
- Divorce

## Employee Signature

Print Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_