FRMS Benefit Program

2024 Benefit/Change Request Form

	Step 1 - Check Coverage Boxes			Step 2 - Check Tier/Amount Coverage			Step 3 - Sign & Return
MEDICAL	**No Change**	**Enroll / Change**	**Decline Coverage**	**Employee Only**	**Employee + 1 Dependent**	**Employee + Family**	**Benefit Election Form**
							I affirm that the benefit selections made confirm my intent for the 2024 plan year.
Blue Shield	Check one box						
Premium EPO							
Premium PPO							
Basic PPO							
Kaiser							**Print Name**
Premium HMO							
Basic HMO							
				Check one box (only if "Enroll/Change" box is checked)			
SUPPLEMENTAL LIFE*	**No Change**			**Enroll / Change**			**Employee Signature**
Employee Life				SEE BENEFITS CONTACT PERSON			
Spouse Life							
Dependent Child Life							**Date**
							Upon completion return to Finance

* May require approval through the Evidence of Insurability (EOI) process.