Benefits Enrollment Form 2026

Instructions: Please complete Section 1 and any other section, as appropriate. Sign and date this form.

TYPE OF ENROLLMENT
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Change
- ☐ Cancellation

FOR HEALTH PLAN USE ONLY

Effective Date of Coverage:

1. Employee Data (please print) ☐ Change in address

NAME (LAST, FIRST, M.I.)	EMPLOYEE NUMBER	DATE OF BIRTH		
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**	**SEX (M/F)**	**MARITAL STATUS (SINGLE, MARRIED, DIVORCED, WIDOWED, SEPARATED)**	

2. Health Plan (pre-tax)

(a) Choose your Health Plan Option:

☐ Basic ☐ No Coverage

(b) Choose your Level of Coverage:

☐ Employee only ☐ Employee plus child(ren) ☐ Employee plus spouse ☐ Family

Please refer to the Benefits Briefing for monthly premium costs.

2. Dental Health Plan (pre-tax)

(a) Choose your Dental Plan Option:

☐ Employee only ☐ Employee plus child(ren) ☐ Employee plus spouse ☐ Family ☐ No coverage

Please refer to the Benefits Briefing for monthly premium costs.

3. Vision Plan (pre-tax)

(a) Choose your Dental Plan Option:

☐ Employee only ☐ Employee plus child(ren) ☐ Employee plus spouse ☐ Family ☐ No coverage

Please refer to the Benefits Briefing for monthly premium costs.

NAME (LAST IF DIFFERENT, FIRST, M.I.)	DATE OF BIRTH (MM/DD/YY)	SEX (M/F)	SOCIAL SECURITY NUMBER	HEALTH	DENTAL
EMPLOYEE					
SPOUSE					
CHILD					
CHILD					
CHILD					

4. Voluntary Benefits: Please contact Human Resources if you would like to add any other voluntary benefits such as STD, Accident Insurance, or Critical Illness insurance.

5. Other Coverage

Do you or your dependent(s) have additional health coverage?
If yes, provide name of carrier, address, and contract number. ☐ Yes ☐ No

Do you or your dependent(s) have additional dental coverage?
If yes, provide name of carrier, address, and contract number. ☐ Yes ☐ No

11. Signature

I hereby apply for the coverages for which I am entitled under the terms of the Program. I understand my benefit will automatically be paid on a before-tax basis and I authorize them to be withdrawn from my paycheck. I understand I cannot change my elections during the year unless I have a qualified change in family status and I notify my employer within 30 days from the event. My signature below affirms that all information and statements on this form are complete and true to the best of my knowledge. I understand that any misrepresentations on this document may be cause for corrective action, up to and including termination, and may result in my coverage being void as of its effective date with no benefits payable. I understand that these elections will remain in effect until I make a new election during a future annual enrollment or qualified family status change, or if my full-time status/employment with the company ends.

SIGNATURE DATE

WAIVER OF COVERAGE:
I WAIVE COVERAGES: I hereby certify that I have been offered the opportunity to participate in the benefit program. Furthermore, I understand that unless I meet the Special Enrollment requirements of the plan, I will be required to wait until the next open enrollment period to elect coverage as a late entrant in the medical, dental, and vision plans.

SIGNATURE DATE

Please return this form to HR at hr@dawson3d.com, fax 432-818-2888, or to your supervisor