Employee Election Form

Medical, Dental and Vision Plans

New Subscriber

First Name:	MI:	Last Name:
Address:		Apt #:
City:	State:	Zip Code:
Social Security #:	Phone #:	
Date of Birth: (MM-DD-YYYY)	Gender: M F	Marital Status: Single Married
Personal Email:	Work Email:	
NED ID:	Full Time Hire Date: (MM-DD-YYYY)	
Award #:	Award Period: Start	End

FAES USE:	Requested Effective Date: (MM-DD-YYYY)	New Hire	Special Enrollment	Open Enrollment

DEPENDENTS

Name: (Last, First, MI)	Relationship to Subscriber:	Social Security #:	Birth Date (MM-DD-YYYY)	Gender M F	Same Address as Subscriber
	Spouse				☐ Y ☐ N
	Dependent				☐ Y ☐ N
	Dependent				☐ Y ☐ N
	Dependent				☐ Y ☐ N

Spouse or Dependent's Address: (if address is different from subscriber)

Institute (select one below):

NCATS	NIA	NIDA	NIMH	CC
NCCIH	NIAAA	NIDCD	NIMHD	CIT
NCI	NIAID	NIDCR	NINDS	CSR
NEI	NIAMS	NIDDK	NINR	FIC
NHGRI	NIBIB	NIEHS	NLM	OD
NHLBI	NICHD	NIGMS		

Health Plan: AETNA Signature Administrators-PPO

Select Level of Coverage:

Individual

Family

If your spouse works at the NIH, please list their full name here:______________________________

Employee Signature:	Date
FAES Representative Signature:	Date