

Please call 888-564-9669 if you need help filling out this form — ask for Group Member Account Services

Employee name:	Employee Social Security Number:
Employer name:	Employer Identification Number (EIN): <i>*required*</i>
Payroll contact:	Contact phone number:
Fax number:	Contact e-mail:

Which health benefit plan did the employee enroll in? Plan name/number: \_\_\_\_\_

Including the employee, who in this family is currently enrolled (or will be enrolled) in your health benefit plan?

<i>List names</i>	<i>Original effective date</i>	<i>Medical effective date</i>	<i>Dental effective date</i>	<i>Vision effective date</i>	<i>Prescription effective date</i>
1) Employee:					
2) Spouse:					
3) Dependent:					
4) Dependent:					
5) Dependent:					
6) Dependent:					

(Attach an additional sheet of paper if necessary)

**Note: FHIAP subsidizes medical, prescription, vision and dental premiums only.**

Total **Monthly** medical/prescription/vision/dental cost to *employer* for this family \$ \_\_\_\_\_

**Monthly** amount *employer* contributes to employee coverage (*subtract*) \$ — \_\_\_\_\_

**Monthly** amount *employer* contributes to family coverage (*subtract*) \$ — \_\_\_\_\_

**Monthly** amount employee owes to *employer* for coverage =\$ \_\_\_\_\_

Does this payroll deduction include any other amounts besides medical, prescription, vision, or dental?

Yes  No If yes, how much **per check?** \_\_\_\_\_ What does this deduction cover? \_\_\_\_\_

**Insurance deductions taken:**

52 times per year  48 times per year  26 times per year  24 times per year  12 times per year  
 Other: \_\_\_\_\_ Please explain: \_\_\_\_\_

**Does the payroll check date reflect the premium for:**

prior pay period  same pay period  in advance for next pay period

**Please mail or fax completed form to:**

FHIAP Attn: MAS Rep: \_\_\_\_\_

P.O. Box 5880

Salem, OR 97304-0880

Toll-free fax: 866-843-8936 ● Local fax: 503-378-4678 ● E-mail: mas.fhiap@state.or.us

Reservation Number: \_\_\_\_\_ Date: \_\_\_\_\_