MEMBER ENROLLMENT FORM

2025 Resorts Casino Hotel Health Plan

EMPLOYEE INFORMATION		
Department:	**Position:**	
Employee Name:	**Employee ID Number:**	**Status:** Full-Time
Address:	**Email:**	

Medical Plan Selection (Check One)

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Aetna Medical Plan with Non-Tobacco Incentive*	☐	☐	☐	☐
Aetna Medical Plan with Tobacco*	☐	☐	☐	☐
Waive/Opt-Out	☐			

* These plans only include Medical and Rx coverage

Dental Plan Selection (Check One)

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Delta Dental Dental Plan	☐	☐	☐	☐
Waive/Opt-Out	☐			

Vision Plan Selection (Check One)

	Employee	Employee + 1	Family
EyeMed Vision Plan	☐	☐	☐
Waive/Opt-Out	☐		

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Benefit Plan Dependent Information

Please include all dependents that you would like covered in 2025*

Dependent Name	Relationship	SSN	Date of Birth	Gender (M/F)	Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

* You will be required to provide documentation for member additions. For example: SS Cards, Birth Certificates, Marriage Certificates, etc.

Employee Signature:_____ **Date:**_____

HUMAN RESOURCES ONLY