

BeneFITs

ASSOCIATE ENROLLMENT FORM REQUEST

TO: PAYROLL/BENEFITS DEPARTMENT

FROM: (SYSTEM NAME): _____ COMPANY: Cable One, Inc.

Please Check One:

New Hire – Full Time

Effective Date: _____

Temp to Full Time

Effective Date: _____

Part Time to Full Time Status

Effective Date: _____

ASSOCIATE INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Home Address: _____ City: _____ St: _____ Zip Code _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Marital Status: Married Single Same Gender Domestic Partners
(Certification of Eligibility Required)

Benefits Eligibility Date: _____

Pay Frequency: Bi-Weekly

Hire / Rehire Date: _____ If Rehire, service re-calc date: _____

Annual Base Salary: \$ _____ System/Dept. # _____

Company Code No.: 11 Payroll ID No. _____

DEPENDENT INFORMATION:

Spouse:

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security No. _____ Relationship: Spouse

Children:

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security No. _____ Relationship: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security No. _____ Relationship: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security No. _____ Relationship: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security No. _____ Relationship: _____

Supplemental documentation is required for any dependent with a different last name than that of the associate.
Copy of marriage license, birth certificate, etc., are acceptable documents.