Benefit Enrollment/Change Form

A. Employee Information (*All information is required*)

First Name:	MI:	Last Name:	
SSN#:	Date of Hire:		
Date of Birth:	Gender: ☐ M or ☐ F	Marital Status:	
Address:	City:	State:	Zip:
Daytime Phone: ( )	Home phone: ( )	Email:	

B. Change of Status/Coverage

Date of Qualifying Event:		☐ Add Dependent	☐ Change Name
☐ Open Enrollment	☐ COBRA / Term. of Employment	☐ Drop Dependent	☐ Change Address
☐ New Enrollment	☐ Medicare	☐ Birth / Death	☐ Other _____
☐ Reduction in Hours	☐ Other Coverage	☐ Marriage / Divorce	

C. Medical Plan Options (*If electing coverage please make a selection in both 1 & 2*)

1. Plan Election	☐ Copay Plan	☐ HSA Plan	☐ Decline Coverage (please complete sections E. & G.)	
2. Coverage Election	☐ Employee only	☐ Employee + Spouse	☐ Employee + Children	☐ Family

D. Dependent/Spouse Information (*Must be completed for coverage of dependents*)

Name (Last, First, MI)	Relationship	Birth date	SSN	M/F	Disabled (Y/N)	Please check below to include on medical plan
						☐ Medical
						☐ Medical
						☐ Medical
						☐ Medical

E. Other Insurance Coverage Information Please check one:

☐ I have enrolled thru the state or federal Marketplace	☐ I have other insurance coverage	☐ I do not have other insurance coverage	☐ I have other insurance coverage, but intend to cancel that coverage

Policyholder's Name:	Policyholder's Date of Birth:	
Insurance Co. Name:	Policy Number:	Group Number:
Insurance Co. Address:	Names of covered individuals:	

F. Health Savings Account

☐ Yes, I would like to set up a Health Savings Account (This option is available if you enroll in the HSA plan).

Your annual deduction will be divided into equal amounts and deducted from each pay period throughout the year.

I elect to have an **ANNUAL** deduction of $_____(maximum of $3,450 for employee-only coverage, or $6,900 for all other levels of coverage) reduced from my salary before taxes to reimburse me for qualified expenses which I incur during the plan year. Maximum contribution to the HSA Plan will be reduced by company contribution. Employees who are age 55 or older can make a catch-up contribution of $1,000 in addition to IRS maximums.

G. Enrollment Waiver (*check box only if declining coverage*)

☐ I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.

☐ I understand by not enrolling in this plan or a Marketplace health plan as mandated by PPACA, that I may be subject to a tax penalty.

H. Employee Authorization

I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease.

I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

_____ _____

Employee Signature Date