2023/2024 BENEFITS ELECTION FORM

REASON FOR ENROLLMENT OR CHANGE (Check all that apply)				REASON FOR CHANGE	
New Enrollment:	☐	Add Dependent:	☐	Marriage:	☐
Open Enrollment:	☐	Remove Dependent:	☐	Birth:	☐
Rehire:	☐	Name Change:	☐	Divorce:	☐
Enrollment Change:	☐	Address Change:	☐	Loss of Eligibility:	☐
Other:	☐			Death:	☐
Effective Date: (mm/dd/yyyy)				Adoption:	☐
				Date of Change: (mm/dd/yyyy)	

Part 1: EMPLOYEE INFORMATION - (Please complete this section even if you will decline your benefits)

Name:			Hire Date: (mm/dd/yyyy)		D.O.B:
Address:			SSN:		Phone:
City:	State:	Zip:	Gender: M: ☐ F: ☐		

Part 2: DEPENDENT INFORMATION (S = Spouse / C = Child) M = Medical / D= Dental / V = Vision

First Name:	Last Name:	SSN:	Date of Birth: (mm/dd/yyyy)	Gender:	Coverage Selection:
				S M☐ F☐	M☐ D☐ V☐
				C M☐ F☐	M☐ D☐ V☐
				C M☐ F☐	M☐ D☐ V☐
				C M☐ F☐	M☐ D☐ V☐
				C M☐ F☐	M☐ D☐ V☐

Part 3: UNITED HEALTHCARE MEDICAL PLAN OPTIONS

		ENROLLING - CHECK ONE BOX OF THE FOLLOWING MEDICAL OPTIONS			
Medical (M)	Enroll: ☐ / Waive: ☐	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
UNITED HEALTHCARE PLAN AXKQ OPTION 1		$74.41 ☐	$223.24 ☐	$223.24 ☐	$372.06 ☐
UNITED HEALTHCARE PLAN AXKO OPTION 2		$86.88 ☐	$248.17 ☐	$248.17 ☐	$409.47 ☐
UNITED HEALTHCARE PLAN CG5P, HSA OPTION 3		$77.85 ☐	$230.00 ☐	$230.00 ☐	$382.15 ☐

		ENROLLING - CHECK ONE BOX OF THE FOLLOWING DENTAL OPTIONS			
Dental (D)	Enroll: ☐ / Waive: ☐	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
GUARDIAN DENTAL PLAN		$7.19 ☐	$14.59 ☐	$17.86 ☐	$26.91 ☐

Part 4: GUARDIAN VISION PLAN

		ENROLLING - CHECK ONE BOX OF THE FOLLOWING VISION OPTIONS			
Vision (V)	Enroll: ☐ / Waive: ☐	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
GUARDIAN VSP CHOICE		$1.72 ☐	$2.89 ☐	$2.95 ☐	$4.67 ☐

PART 5: DECLINATIONS/WAIVERS OF ENROLLMENT

IMPORTANT! If you are waiving your right or your dependents' rights to coverage under this plan, you must declare the reason in writing below. Failure to declare your reason for waiving coverage may limit your opportunity to join the plans later and could result in denial of claims for pre-existing conditions.

I have been given the opportunity to participate in the benefit plans but after due consideration, I have elected NOT to participate in each of the categories checked below.

DESIGNATED WAIVERS	MEDICAL	DENTAL	VISION		
Employee	☐ –	☐ –	☐ –		
Spouse	☐ –	☐ –	☐ –		
Child	☐ –	☐ –	☐ –		

REASON DECLINING BENEFITS (CHECK ONE BOX)	☐ –	HAVE OTHER QUALIFYING COVERAGE
	☐ –	HAVE MEDICAID / MEDICARE
	☐ –	HAVE INDIVIDUAL COVERAGE
	☐ –	OTHER -

I understand that by checking any of the boxes above, I will not be applying for the coverage above and I will not be entitled to those benefits. I further understand that by applying for coverage at a future date I may be asked to provide health status information for purposes of group rate setting. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed.

PART 6: PAYROLL DEDUCTION AUTHORIZATION AGREEMENT & EMPLOYEE CERTIFICATION

I HEREBY:

1) Request coverage for the Group Insurance for which I am or may become eligible. *(Must be full time employee working a minimum of 30 hours per week)*

2) Authorize my employer to make necessary payroll deductions for the contributions required for insurance and agree to the contributions.

3) State that I became an employee on the date stated above.

4) Understand that any person who, with intent to defraud or knowing that they are facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I have reviewed the statements on this application and they are true and accurate.

5) Understand that if I miss a week of work that I will have to pay my usual deduction amount plus an additional admin fee in the amount of $74.14. *(This admin fee will only be charged for your medical benefits, not if you have only dental and/or vision coverage)*

6) Understand that if I request to take part in "gap insurance" between my contracts that I meet the requirements of the policy *(request a copy from HR Dept.)*

7) I understand if I have a "qualifying event" I must notify the Plan Administrator within 30 days of this change in order to modify or revoke this benefit election during the Plan Year.

Signature _____ **Date** _____