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| **Office Use Only** |
| Company Info. | Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Enrollment | 🞏 New Hire 🞏 Rehire 🞏 Open Enrollment 🞏 Qualifying Event |
| Change | 🞏 Personal Information 🞏 Beneficiary 🞏 Add Dependent 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Termination | Termination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Qualifying Event | 🞏 Marriage/Divorce 🞏 Birth/Adoption 🞏 Court Order 🞏 Loss of Coverage 🞏 FT to PT (Last Day of FT Coverage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  |

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| **Employee Information**  |
| Social Security Number | Last Name | First Name | MI |
| Home Street Address Apt | City, State, Zip |
| Date of Birth | Date of Hire | Gender (required)🞏 Male 🞏 Female  | Employment Status🞏 Full-Time 🞏 Part-Time |

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| **Dependent Information** |
| **Last Name** | **First Name** | **SSN** | **Date of Birth** | **Gender** **(M / F)** | **Relationship** | **Coverage** |
|  |  |  |  |  | 🞏 Spouse 🞏 Child  | 🞏 Medical 🞏 Dental 🞏 Vision  |
|  |  |  |  |  | 🞏 Spouse 🞏 Child  | 🞏 Medical 🞏 Dental 🞏 Vision  |
|  |  |  |  |  | 🞏 Spouse 🞏 Child  | 🞏 Medical 🞏 Dental 🞏 Vision  |
|  |  |  |  |  | 🞏 Spouse 🞏 Child  | 🞏 Medical 🞏 Dental 🞏 Vision  |
|  |  |  |  |  | 🞏 Spouse 🞏 Child  | 🞏 Medical 🞏 Dental 🞏 Vision  |

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| **Elections** |
| **Premier Medical** | **Value Medical** | **Bronze Medical** | **Enhanced Dental** | **Basic Dental** | **Vision** |
| 🞏 Employee Only$654.17 | 🞏 Employee Only$611.57 | 🞏 Employee Only$577.70 | 🞏 Employee Only$30.90 | 🞏 Employee Only$25.74 | 🞏 Employee Only$13.34 |
| 🞏 Employee + Spouse$1,284.61 | 🞏 Employee + Spouse$1,195.15 | 🞏 Employee + Spouse$1,127.41 | 🞏 Employee + Spouse$59.54 | 🞏 Employee + Spouse$49.65 | 🞏 Employee + Spouse$18.94 |
| 🞏 Employee + Children$1,188.27 | 🞏 Employee + Children$1,109.86 | 🞏 Employee + Children$1,047.21 | 🞏 Employee + Children$73.62 | 🞏 Employee + Children$55.76 | 🞏 Employee + Children$19.25 |
| 🞏 Family$1,825.58 | 🞏 Family$1,693.44 | 🞏 Family$1,596.92 | 🞏 Family$110.42 | 🞏 Family$85.10 | 🞏 Family$28.59 |
| 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **River Health Primary Care Option** |
| 🞏 Employee Only$54.00 | 🞏 Employee + Spouse$74.00 | 🞏 Employee + Children$134.00 | 🞏 Family$164.00 | 🞏 DeclineReason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I have read this form and the other materials given to me about my benefits and certify the information I have supplied is correct. I understand that misstatements, misrepresentations, or omissions may result in my coverage being canceled. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary action up to and including termination.

I also understand that the benefit coverages I elect on this form will be in effect for the entire plan year unless I experience a qualified status change event and request a change to my benefits within 30 days of such event. By signing and submitting this enrollment form, I authorize my employer and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I also understand that I am liable for these deductions pursuant to such authorization and acknowledge that it is my responsibility to verify that these payroll deductions are correct. I will notify human resources immediately in writing upon discovering any discrepancy.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_