2019-20 ITL ENROLLMENT FORM

Per ACA requirements, all individuals must be enrolled in a qualified health plan that covers minimum essential coverage or be subject to tax penalties.

❑ **CHANGE ONLY**

A. EMPLOYEE INFORMATION

Social Security Number	Last Name	First Name	M.I.	Date of Birth	

Home Street Address: Apt.	Home Phone	Date of Hire	Hours/week

City, State, Zip	Gender □Male □Female	Job Title	Salary $_____	□Hourly □Salary
		□Management	□Non-Management	

Marital Status: □Married □Single □Divorced □Widowed E-mail:

New Enrollment Qualifying Event: □New Hire □Open Enrollment □Loss of other coverage □Other: _____

B. MEDICAL PLAN **HEALTH SAVINGS**

Check One:	Medical Coverage Type:		Contribution per pay check to my Health Savings:
□I ELECT **OPTION 1- HDHP SILVER - $3000 DED** □I ELECT **OPTION 2 - HDHP BRONZE-$5500 DED** □I **WAIVE** my right to group health coverage.	□Employee only □Employee and Spouse □Employee and Children □Family	Are you or any of your dependents eligible or enrolled in Medicare? Circle yes no	$_____ **Employer will contribute $.25 for every dollar up to allowed amount in combination**

You Must Complete this Section:

Do you or any of your covered dependents have other group health coverage? □Yes □No

If yes, Name of Insured: _____ Insurance Policy Number: _____

Insurance Co Name: _____ Insurance Co Address _____

Place of Employment: _____ _____

C. DENTAL PLAN - VOLUNTARY (PAID BY EMPLOYEE)

Check One:	Dental Coverage Type:	
□I **ELECT** group dental coverage □I **WAIVE** my right to dental coverage	□Employee Only □Employee and Spouse □Employee and Children □Family	

D. VISION PLAN - VOLUNTARY (PAID BY EMPLOYEE)

Check One:	Vision Coverage Type:	
□I **ELECT** group vision coverage □I **WAIVE** my right to vision coverage	□Employee Only □Employee and Spouse □Employee and Children □ Family	

G. FAMILY MEMBERS TO BE COVERED

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY	DATE OF BIRTH	GENDER
Spouse						
Child						
Child						
Child						
Child						
Child						

I certify that all information supplied on this form is true to the best of my knowledge and that I have read and understand the information entitled "Enrollment Information" provided in addition to this form.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

ENROLLMENT INFORMATION

ACCEPTANCE: By signing this form you are certifying that all information supplied on this form is true to the best of your knowledge. You understand that all benefits for yourself and your eligible dependents will be provided in accordance with the plan contract. You agree to abide by the terms and conditions governing membership and receipt of health services covered by thge plans in which you have enrolled. You authorize your employer to reduce your salary (per IRS regulation Section 125) in an amount necessary to pay for your benefit elections. You understand that your salary reduction cannot be revoked or changed unless you experience a "Change in Status" that allows a change in your election. If you experience a change in status, you may be able to make certain changes to your benefits that fall under the Sec 125 regulation. Your benefit change must be consistent with the status change and should be requested in writing within 31 days of the event. Additional paperwork may be required from you at that time. This signature is also to verify: (1) the accuracy of the information contained on this form; and (2) your decision to elect or decline participation in your employer's benefit plans.

SPECIAL LATE ENROLLMENT RIGHTS: In order for these rights to apply to you, you must state in writing that the reason you are currently declining coverage is because you are covered under other health insurance coverage. You may be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

CHANGE IN STATUS: If you experience one of the following changes in status, you may be able to make certain changes to your benefits that fall under the Sectionb 125 regulation. Your benefit change must be consistent with the status change and be requested in writing within 31 days of the event. Additional paperwork may be required from you at that time.

- Change in employee's legal marital status: Marriage, divorce, death of spouse
- Change in number of dependents: Birth, adoption, placement for adoption, death of dependent
- Change in employment status of employee or spouse: Termination, commencement of employment, coverage of spouse, loss or gain of benefit eligibility of spouse or spouse's open enrollment period
- Dependent eligibility changes: Dependent is newly or no longer eligible (i.e. too old, married, etc.)
- Residence change of an employee, spouse or dependent
- Material benefit change of employee or spouse, including spouse's annual open enrollment

If you have questions, please contact the Group Benefits Department at (615) 356-1700