Choice Homecare

2018 - 2019 PLAN YEAR ELECTIONS

Effective Date: ____________________

Location: ____________________

Basic Data: Please report any changes to the Human Resources Department Immediately			
Last Name	First Name		Date of Hire
SSN	Date of Birth	Gender	Marital Status
Address			Phone #
City	State	Zip	Email Address

INSTRUCTIONS:

STEP ONE: IF YOU'RE MAKING ANY CHANGES TO YOUR CURRENT COVERAGE, CHECK HERE & CONTINUE TO SECTION 1. (i.e. address change, adding or dropping a dependent, adding new benefits) ☐

STEP TWO: IF YOU ARE WAIVING/DECLINING ALL COVERAGES, CHECK HERE. SKIP THE FOLLOWING SECTIONS AND BE SURE TO SIGN & DATE THE BACK PAGE. ☐

STEP THREE: IF YOU ARE ENROLLING AS A NEW HIRE, CHECK HERE AND CONTINUE TO SECTION 1. ☐

NOTE: If you are enrolling your dependents (spouse and/or children), additional information is required on the back of the page in Section 5. (dates of birth, social security numbers)

MAKE SURE TO CHECK ALL APPROPRIATE BOXES ON BOTH PAGES.

SECTION 1

MEDICAL - BI-WEEKLY PREMIUM

	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILDREN	EMPLOYEE & FAMILY
OPTION 1 - HDHP	☐ $75.29	☐ $271.04	☐ $195.78	☐ $391.50
OPTION 2	☐ $94.50	☐ $315.22	☐ $230.32	☐ $451.04
OPTION 3	☐ $126.53	☐ $388.90	☐ $287.99	☐ $550.36
				IF WAIVING COVERAGE, CHECK THE BOX ☐

SECTION 2

DENTAL - BI-WEEKLY PREMIUM

	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILDREN	EMPLOYEE & FAMILY
DENTAL PLAN	☐ $14.00	☐ $28.43	☐ $38.84	☐ $57.08
				IF WAIVING COVERAGE, CHECK THE BOX ☐

SECTION 3

VISION - BI-WEEKLY PREMIUM

	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILDREN	EMPLOYEE & FAMILY
VISION PLAN	☐ $2.76	☐ $5.84	☐ $6.04	☐ $9.83
				IF WAIVING COVERAGE, CHECK THE BOX ☐

SECTION 4

VOLUNTARY LIFE/AD&D

	EMPLOYEE	CHILD(REN)	SPOUSE	SPOUSE INFO
LIFE BENEFIT AMOUNT		$10,000		NAME:
BI-WEEKLY COST (age rate)		$2.54 (Monthly)		
WAIVED COVERAGE	☐	☐	☐	DATE OF BIRTH:
CHECK BOX ABOVE IF WAIVING VOL LIFE/AD&D				

BENEFICIARY

Must equal 100%

Name	Relationship	%	DOB
Primary: 1) Name	Relationship	%	DOB
Primary: 2) Name	Relationship	%	DOB
Contingent: 1) Name	Relationship	%	DOB
Contingent: 2) Name	Relationship	%	DOB

SECTION 5

DEPENDENT COVERAGE (enter information if you are covering/dropping a spouse or any children)

Name	Gender M / F	Date of Birth	SSN	CHECK BOX
Spouse				☐ Add ☐ Drop
Child 1				☐ Add ☐ Drop
Child 2				☐ Add ☐ Drop
Child 3				☐ Add ☐ Drop
Child 4				☐ Add ☐ Drop
Child 5				☐ Add ☐ Drop
Child 6				☐ Add ☐ Drop

SECTION 6

SHORT-TERM DISABILITY - EMPLOYEE PAID

Date Eligible or Date of Rehire:	Annual Salary:

Rates* per $10 of Covered Salary and additional plan information is included on page 16 in the Employee Benefit Guide.

Calculate your per-paycheck cost for this coverage, complete the calculations below:

______________________ / 52 = ______________ X (.60) / 10 = __________ X (age rate) _____________ / 26 = ___________________

Annual Salary (divided by 52) (times .60) (divided by 10) X (Your age Rate) (divided by # paychecks per year) = Cost per Paycheck

☐ YES, I would like to participate in the Short Term Disability plan.

☐ NO, I do not wish to participate in the Short Term Disability plan and am waiving coverage.

SECTION 7

LONG-TERM DISABILITY - EMPLOYEE PAID

Date Eligible or Date of Rehire:	Annual Salary:

Rates* per $100 of Covered Salary and additional plan information is includedon page 18 in the Employee Benefit Guide.

Calculate your per-paycheck cost for this coverage, complete the calculations below:

______________________ X __________ / 100 _______________ / 26 = ___________________

Monthly Earnings (times Your age Rate) (divided by 100) = Monthly Cost (divided by # paychecks per year) = Cost per Paycheck

☐ YES, I would like to participate in the Long Term Disability plan.

☐ NO, I do not wish to participate in the Long Term Disability plan and am waiving coverage.

SIGNATURE OF ACCEPTING OR DECLINING COVERAGE REQUIRED BELOW

I hereby apply for the coverage now being offered to me and my dependent(s), if any, as shown on this form. I authorize CHOICE HOMECARE to deduct the cost of benefits I have elected from my pay. I declare that all entries on this form are true and complete and that any material misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s) (if any) from the original effective date of coverage. If I am not actively at work, or my dependents are not actively at work or are unable to engage in all the usual duties of a person of like age and sex, the effective date of all non-medical coverage will be delayed until I return to work, or my dependent resumes usual duties. I authorize any health care professional or entity to give representatives of the health plan, or any of their designees, any and all records of information pertaining to the medical history or services rendered to us for any administrative purposes, including evaluation of an application or claim, and for any analytical or research purposes as allowable under the Health Insurance Portability and Accountability Act of 1996, as amended. I also authorize, on behalf of myself and any dependents, the use of a Social Security Number for purpose of identification. A photographic copy of this authorization shall be valid as the original. This summary of benefits is not a legal description and is provided only to assist in answering general questions. Other limitations and exclusions are listed in the contracts provided to your employer.
I acknowledge that I have been given the opportunity to enroll in the pre-tax option for my health insurance premiums for the plan year of 2017-2018 and understand that, if I choose to enroll, my pre-tax election is irrevocable unless there is an IRS qualified status change in my family situation. If I elect to enroll in the Premioum Only Plan, I further understand that the "evergreen" election will be invoked and will automatically carry over from year to year until and unless I notify the plan administrator by completing another election form declining participation. Any changes will be effective as of the first day of the next plan year. The salary reduction amounts for the carry-over election will be adjusted automatically to reflect any increase or decrease in the cost of premiums.

I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next annual enrollment unless that change or revocation is on account of and consistent with a change in status.

_______________________________ _______________________

Signature Date