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Union county #254

GROUP BENEFIT ENROLLMENT FORM and CHANGE FORM

SHADED AREAS FOR HUMAN RESOURCES USE ONLY

DATE OF HIRE:	LOCATION:	EFF. DATE OF CHANGE:

EXPLANATION: ☐NEW ENROLLMENT ☐PLAN OPTION CHANGE ☐ADD/REMOVE DEPENDENTS ☐TERMINATION
☐NAME CHANGE ☐ADDRESS CHANGE ☐OTHER: _____

1. EMPLOYEE PROFILE

Employee Name		***Employee ID #***	
Maestro Member ID #		***Social Security #***	
Street Address		***Date of Birth***	
City, State, Zip		***Home Phone #***	
Email Address (Required)		***Gender:***	☐Male ☐Female
Marital Status	SINGLE☐ MARRIED☐ WIDOWED☐ SEPARATED☐ DIVORCED☐		

2. COVERAGE ELECTION SECTION

	MEDICAL PLAN	***DENTAL PLAN***	***Plan Option*** *(choose one)*
Coverage Level	**Indicate with "X"**	**Indicate with "X"**	
Employee Only			☐ Direct Primary Care ☐ Traditional
*Employee + Spouse**			
Employee + Child(ren)			
*Employee + Family**			
WAIVE COVERAGE	Initial here to **decline medical** coverage _____	Initial here to **decline dental** coverage _____	

* PLEASE NOTE – If your spouse is eligible to participate in a group health plan through his/her employer, he/she is NOT eligible to participate in either the Union County Employee or Retiree Health Plan. This applies whether or not he/she chooses to enroll in his/her employer's health plan.

3. DEPENDENT INFORMATION

To be covered, all dependents must be listed below; Dependents not named are not covered. Dependents are not eligible if employee coverage is not elected. Indicate: a dependent child who is handicapped; a dependent who has any other insurance; and a dependent child who is covered by you due to a QMSCO (Qualified Medical Child Support Order.)

Dependent Name *(X) indicates a change to this member's information*	**Dep. Soc.Sec. # (Must be provided for all dependents)**	**Date of Birth (mm/dd/yyyy)**	**Medical/Dental Coverage Indicate (Add or Drop)**	**Dependent Rel. to you (son, wife, etc)**	**Disabled? (Y or N)**	**Is other insurance available (Y or N)**	**QMCSO? (Y or N)**
( )							
( )							
( )							
( )							
( )							

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4. SPOUSE EMPLOYMENT QUESTIONNAIRE (You must complete if covering your spouse under this Plan)

Coverage question		Special instructions
Is your spouse currently employed?	**Yes** ☐ **No** ☐	**If Yes, please complete following information. If No, please continue to Section 5 of the form.**
Do you and your spouse have the same employer?	**Yes** ☐ **No** ☐	
Spouse Employer Name	**Employment Date**	**Phone Number**
Address		
If employed, does your spouse's employer offer a health plan?	**Yes** ☐ **No** ☐	
Is your spouse currently participating in his/her employer's health plan?	**Yes** ☐ **No** ☐	**If No, please complete section below.**

Please check the appropriate option regarding your Spouse's health plan options:

☐ The employee does not have access to coverage because his/her employer does not offer a health plan.

☐ The employee does not have access to coverage because he/she is Part Time.

☐ The employee does not have access to coverage because he/she is still in their waiting period. Date eligible to enroll for coverage: ____/____/____

5. ENROLLEE ACKNOWLEDGEMENT SECTION

Initial Below	*PLEASE CAREFULLY READ the acknowledgement below and initial in the left column.*
LINE A	*I acknowledge that I have read and fully understand the ENROLLMENT DISCLOSURE NOTICE. I further acknowledge that I have reviewed a copy of the Summary Plan Description and understand that a copy of the Summary Plan Description will be provided to me.*
LINE B	*I acknowledge that I must notify the Human Resources Department within 30 days of a Qualifying Event in order to change coverage status due to the Qualifying Event. I also acknowledge that I fully understand the provisions for Late Enrollment under this plan and Open Enrollment under this Plan.*
LINE C	*I acknowledge that I fully understand the applicable cost to me for each group benefit plan and how participation in this Plan will affect my weekly "take-home" pay. I also acknowledge that I fully understand coverage, exclusions, and the provisions for adding or dropping coverage for myself and/or my dependents.*
LINE D	*I acknowledge and understand that my spouse's employment status effects eligibility under my group health plan. I further acknowledge that I am responsible for communicating changes in my spouse's employment to my employer.*
LINE E	*I acknowledge and understand the Plan Declaration shown below.*

Employee Signature: *Date:*

INDICATION OF THE QUALIFYING CHANGE IN FAMILY STATUS

Qualifying Change in Family Status *(must check one if this is a Special Enrollment Change Form)*
Qualifying Event Date: _____/_____/_____

Qualifying Event Description	**Human Resources use only**
❑ Marriage;	
❑ Divorce or Legal Separation;	
❑ Death of a spouse or child;	
❑ Birth or adoption of a child;	
❑ Termination of your spouse's employment;	
❑ Commencement of your spouse's employment;	
❑ Change from part-time to full-time, or vice versa, by you or your spouse;	
❑ The taking of an unpaid leave of absence by either you or your spouse;	
❑ A significant change in your health coverage or your spouse's health coverage attributable to your spouse's job;	
❑ Enrollment in Market Place Coverage	
☒ Open Enrollment	

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PLAN DECLARATION

Your elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless you make an election change permitted under the Plan. You may change my elections during the Plan Year only if (i) you experience a "status change". As defined under the Plan, and if your change in elections is consistent with that "status change", (ii) you exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) you qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. The cost of a benefit option that you have elected under the Plan may change from one Plan Year to the next and your payroll deductions will automatically change accordingly unless you submit a new Election Form during the appropriate annual election period to change or terminate that coverage. During a Plan Year, if there is a change in the cost of a benefit option that you have elected, the Employer may automatically increase the payroll deductions, if any, you are required to make per pay period to pay for that benefit option. Except to the extent that you are permitted to make a change under the Plan, the payroll deductions elections you have made will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options you have elected.

The employer may modify your benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, the employer retains the right to amend or terminate coverage under a benefit option. The employer may modify your elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires you to provide health coverage for a dependent.

ENROLLMENT DISCLOSURE NOTICE

I hereby apply for self-funded group insurance coverage. I agree the copy of my signature or copy of this form may be accepted as my signature. I authorize necessary deductions from my salary, account or dues for any contributions required. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give the insurer, including its reinsurer, such information. A photographic and/or faxed copy of this authorization shall be as valid as the original. I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application, the coverage applied for shall become effective in accordance with the terms of the Plan Document.

I understand that my employer, the Plan Sponsor, reserves the right to modify or amend the Plan from time to time at its sole discretion and such amendments or modifications which affect covered persons will be communicated to Participants. Further, the Plan Sponsor reserves the right to terminate the Plan at any time.

I acknowledge that I received and read a copy of the "General Notice of Special Enrollment Rights and Women's Health and Cancer Act Rights of 1998" (see below) and at or before the time I was initially offered enrollment in the health plan. I am aware of the warning in the Notice that I will lose some special enrollment rights for myself and my dependents if I decline coverage because I or my dependents have other coverage, unless I give the Plan written statement that the reason I am declining coverage is because I or my dependents have other coverage. Further, I understand that health coverage once offered and declined, may be elected at a later date as defined the Plan Document's Special Enrollment Rules. Otherwise, no other opportunity will be granted for me or my now eligible dependents to be covered.

I understand that I must meet all eligibility requirements before coverage can become effective. I understand that any falsification will result in denial or cancellation of coverage so that the result is no coverage was ever in effect and any claims paid will be reimbursed by me. By initialing the appropriate bottom section of the front of this application, I acknowledge that all information on the front of this page was entered by me (except for areas indicated for Maestro Health or client use only) prior to my signing this Enrollment Form.

NOTICE OF PARTICIPANT ELECTION IN THE SECTION 125 PLAN

In order to minimize the impact of your insurance deduction from your paycheck, only the deduction for your medical and dental coverage will be made on a pre-tax basis. This means that your insurance will be taken out of your check before taxes are figured. The result will be less taken out of your pay. Your income as reported on your year-end W-2 Form will be reduced by the amount of your insurance contribution. You will pay less tax. This feature in our program is permitted under Section 125 of the Internal Revenue Code and is better known as a "Cafeteria Plan."

I understand that I shall reduce my salary by an amount equal to my share of the cost of my health insurance and this money will automatically be deducted from my payroll check. After I sign this Election Form, my salary reduction cannot be changed until the open enrollment period, UNLESS I HAVE A CHANGE IN MY FAMILY STATUS (which includes marriage or divorce, death of a spouse, death of a child, birth or adoption of a child or a change of my spouse's employment status).

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General Notice of Special Enrollment Rights and Women's Health and Cancer Rights Act of 1998

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided you request enrollment and complete the Change Form within 30 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 you request enrollment and complete the Change Form within 30 days after the marriage, birth, adoption, or placement for adoption. You may also elect coverage during the Open Enrollment Period offered once annually at a time specified by the Plan. Please be advised that late enrollment in this plan may affect you or your dependents' eligibility.
Documentation of the special enrollment situation is required.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, this plan provides coverage in consultation with the attending physician for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Physical complications of mastectomy, including lymph edemas.

Benefits for the above medical services and supplies are subject to the same deductible and coinsurance limitations consistent with those established for other services, supplies and procedures that apply under the employee health benefit plan.