

# Health & Welfare Benefits Enrollment Form



Select one:

Office Use Only:

<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Add <input type="checkbox"/> Drop	Eligibility Date: _____ Effective Date: _____
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**Please provide supporting documentation:**

Reason for adding:    \_\_\_ Birth/Adoption    \_\_\_ Marriage    \_\_\_ Loss of Coverage    \_\_\_ Divorce    \_\_\_ Other: \_\_\_\_\_

**EMPLOYEE INFORMATION**

Name: Last	First	Mi	Employee #:	SSN:	Date of Birth:
Address:			City:	State:	Zip Code:
Phone: (    ) -    -			Program:	Status: Single: <input type="checkbox"/>	Divorced: <input type="checkbox"/> Widowed: <input type="checkbox"/> Married: <input type="checkbox"/> Date Of Marriage: _____

**DEPENDENTS**

	Name: Last	First	Date of Birth	*SSN	Do you want to cover this dependent?
Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship					<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship					<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship					<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship					<input type="checkbox"/> Yes <input type="checkbox"/> No

**\*Note:** SSN is **required** to enroll dependants in Health Benefits

Are you or your dependents covered by any other group plan?    Yes     No

If yes, please indicate the name of the covered person, and the name and address of the insurance carrier or health plan.

Name \_\_\_\_\_ Insurance Information \_\_\_\_\_

Name \_\_\_\_\_ Insurance Information \_\_\_\_\_

**BENEFICIARY FOR LIFE INSURANCE ONLY**

For the purpose of Life Insurance, I hereby designate the persons herein named as my beneficiary or beneficiaries:

**Primary**

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Percentage \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_ Primary

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Percentage \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_ Primary

**Contingent**

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Percentage \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_ Contingent

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Percentage \_\_\_\_\_ %  
 Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_ Contingent

Choose one option listed below:

**Option 1.**

**Current Plan**

<b><u>TOBACCO USERS:</u></b>			
<u>CO-PAYMENT</u>	<input type="checkbox"/> <u>12 MONTH RATE</u>	<input type="checkbox"/> <u>10 MONTH RATE</u>	
<input type="checkbox"/> Employee Only	\$100	\$133.34	
<input type="checkbox"/> Employee + Spouse	\$170	\$226.67	
<input type="checkbox"/> Employee + Child	\$150	\$200.00	
<input type="checkbox"/> Employee + Children	\$170	\$226.67	
<input type="checkbox"/> Employee + Family	\$190	\$253.34	

<b><u>NON- TOBACCO USERS:</u></b>			
<u>CO-PAYMENT</u>	<input type="checkbox"/> <u>12 MONTH RATE</u>	<input type="checkbox"/> <u>10 MONTH RATE</u>	
<input type="checkbox"/> Employee Only	\$70	\$93.34	
<input type="checkbox"/> Employee + Spouse	\$140	\$186.67	
<input type="checkbox"/> Employee + Child	\$120	\$160.00	
<input type="checkbox"/> Employee + Children	\$140	\$186.67	
<input type="checkbox"/> Employee + Family	\$160	\$213.34	

**Option 2.**

**High Deductible Health Plan (HDHP)**

<b><u>TOBACCO USERS:</u></b>			
<u>CO-PAYMENT</u>	<input type="checkbox"/> <u>12 MONTH RATE</u>	<input type="checkbox"/> <u>10 MONTH RATE</u>	
<input type="checkbox"/> Employee Only	\$83.00	\$110.67	
<input type="checkbox"/> Employee + Spouse	\$141.10	\$188.14	
<input type="checkbox"/> Employee + Child	\$124.50	\$166.00	
<input type="checkbox"/> Employee + Children	\$141.10	\$188.14	
<input type="checkbox"/> Employee + Family	\$157.70	\$210.27	

<b><u>NON- TOBACCO USERS:</u></b>			
<u>CO-PAYMENT</u>	<input type="checkbox"/> <u>12 MONTH RATE</u>	<input type="checkbox"/> <u>10 MONTH RATE</u>	
<input type="checkbox"/> Employee Only	\$58.10	\$77.47	
<input type="checkbox"/> Employee + Spouse	\$116.20	\$154.94	
<input type="checkbox"/> Employee + Child	\$99.60	\$132.80	
<input type="checkbox"/> Employee + Children	\$116.20	\$154.94	
<input type="checkbox"/> Employee + Family	\$132.80	\$177.07	

NOTE: All covered persons must be non-users of tobacco products of any kind to be eligible to receive the Health and Welfare \$30 per month co-payment discount.

**AUTHORIZATION**

I hereby (1) request coverage under the Group Plan for which I am or may become eligible, (2) authorize EOC to make any necessary deductions required for coverage under the Group Plan, (3) designate the beneficiary indicated on this form to receive the life insurance benefit, if any, payable upon my death, and (4) certify that the information herein is true and correct. I agree that deductions for benefit premiums will be taken on a pre-tax basis in accordance with Section 125 of the IRS tax code.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**DECLINATION**

I decline coverage under FCEOC's group health plan for:

Myself  Family

Spouse (name): \_\_\_\_\_

Dependent (name): \_\_\_\_\_

Reason for declination, check all that apply:

- Voluntary choice not to enroll
- Other coverage (indicate insurance company, policy number and persons covered under the plan  
Insurance Info \_\_\_\_\_)
- Coverage under spouse's plan.
- Other \_\_\_\_\_

I understand that I cannot enroll in FCEOC's group insurance plan until the next open enrollment period and that approval for coverage will be defined by Health Care Reform Law.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**INSTRUCTIONS: The above co-payment rates are effective January 1, 2011. If you have any change in covered person(s) or select a new health plan, you must complete a new Enrollment Form.**