Master Plans

Consolidated Enrollment/Change **Plan Year - 08/01/19-07/31/20**

Effective Date:

Employee Name (Last, First, Middle Initial)	**Social Security Number**		**Date of Birth**	**Marital Status** ☐ Single ☐ Married
Address (Mailing)	**Phone Number**		**Job Title / Occupation**	**Salary**
City, State and Zip	**Gender:** M / F	**Division**	**Hours Worked Weekly**	**Date of Hire**

Enrollment (Check One if it applies)
- ☐ Open Enrollment Period
- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ Acquisition

Change (Check One if it applies)
- ☐ Change Address
- ☐ Add Dependent(s)
- ☐ Cancel Dependent(s)
- ☐ Waive/Dropping Coverage
- ☐ Change Name
- ☐ Insurance Continuation

Family Status Change (Check One if it applies)
- ☐ Add Dependent(s)
- ☐ Cancel Dependent(s)
- ☐ Waive/Dropping Coverage

Action	Dependent Last Name	First Name	Date of Birth	Social Security Number	**Relationship:** - Must be legal spouse or child to be eligible	**Gender** Circle One
☐ Enroll ☐ Add ☐ Change					Self	M / F
☐ Enroll ☐ Add ☐ Change					Spouse	M / F
☐ Enroll ☐ Add ☐ Change					Child	M / F
☐ Enroll ☐ Add ☐ Change					Child	M / F
☐ Enroll ☐ Add ☐ Change					Child	M / F

** MEDICAL **

MEC 1	☐ Employee Only $83.00 per month	☐ Employee + Spouse $103.00 per month	☐ Employee + Child(ren) $103.00 per month	☐ Employee + Family $103.00 per month	☐ Decline Coverage
MEC 2	☐ Employee Only $95.85 per month	☐ Employee + Spouse $145.59 per month	☐ Employee + Child(ren) $136.17 per month	☐ Employee + Family $189.82 per month	
MEC 3	☐ Employee Only $146.75 per month	☐ Employee + Spouse $231.24 per month	☐ Employee + Child(ren) $215.24 per month	☐ Employee + Family $306.30 per month	
MEC 4	☐ Employee Only $210.44 per month	☐ Employee + Spouse $361.81 per month	☐ Employee + Child(ren) $329.77 per month	☐ Employee + Family $496.56 per month	
Ternian Basic	☐ Employee Only $83.18 per month	☐ Employee + 1 $182.76 per month	☐ Employee & Family $265.84 per month		
Ternian Choice	☐ Employee Only $177.25 per month	☐ Employee + 1 $381.91 per month	☐ Employee & Family $556.43 per month		
Ternian Max	☐ Employee Only $271.89 per month	☐ Employee + 1 $581.39 per month	☐ Employee & Family $850.52 per month		

** DENTAL **

Cigna HMO	☐ Employee Only $19.73 per month	☐ Employee + Spouse $52.65 per month	☐ Employee + Child(ren) $52.65 per month	☐ Employee + Family $52.65 per month	☐ Decline Coverage
	Primary choice for dental office __ __ __ __ __ __ Secondary choice for dental office __ __ __ __ __ __ If you do not choose a dental office, one will be assigned to you. Assignments can be changed during the plan year.				
MetLife PPO Low	☐ Employee Only $30.00 per month	☐ Employee + Spouse $61.08 per month	☐ Employee + Child(ren) $77.45 per month	☐ Employee + Family $117.35 per month	
MetLife PPO High	☐ Employee Only $39.58 per month	☐ Employee + Spouse $80.49 per month	☐ Employee + Child(ren) $98.52 per month	☐ Employee + Family $150.37 per month	

Employee Name (Last, First, Middle Initial) _____

** VISION **

MetLife Low	☐ Employee Only $9.21 per month	☐ Employee + Spouse $18.48 per month	☐ Employee + Child(ren) $15.65 per month	☐ Employee + Family $25.79 per month	☐ Decline Coverage
MetLife High	☐ Employee Only $12.55 per month	☐ Employee + Spouse $25.19 per month	☐ Employee + Child(ren) $21.30 per month	☐ Employee + Family $35.13 per month	

**VOLUNTARY LIFE/AD&D **

Please refer to rate chart in Benefit Guide

MetLife	☐ Elect **EMPLOYEE** Life Amount Equal to _____ **(You must also complete the MetLife enrollment form to secure this benefit.)**	Cost = _____	☐ Decline Coverage
MetLife	☐ Elect **SPOUSE** Life Amount Equal to _____ **(You must also complete the MetLife enrollment form to secure this benefit.)**	Cost = _____	
MetLife	☐ Elect **CHILD** Life Amount Equal to _____ **(You must also complete the MetLife enrollment form to secure this benefit.)**	Cost = _____	

** SHORT TERM DISABILITY **

Please refer to rate chart in Benefit Guide

Aflac Disability	☐ Elect Disability Monthly Benefit of _____	Cost = _____	☐ Decline Coverage

** ACCIDENT **

Aflac Accident	☐ Employee Only $13.07 per month	☐ Employee & Spouse $22.71 per month	☐ Employee & Child(ren) $31.40 per month	☐ Employee & Family $41.04 per month	☐ Decline Coverage

	Beneficiary Last Name	First Name	Relation	Social Security Number	Percentage
☐ Primary ☐ Secondary					
☐ Primary ☐ Secondary					
☐ Primary ☐ Secondary					
☐ Primary ☐ Secondary					

** HOSPITAL INDEMNITY **

Aflac Hospital	☐ Employee Only $37.16 per month	☐ Employee & Spouse $73.26 per month	☐ Employee & Child(ren) $62.84 per month	☐ Employee & Family $98.94 per month	☐ Decline Coverage

** CRITICAL ILLNESS **

Aflac Critical Illness	**Employee $5,000**	**Employee $10,000**	**Employee $15,000**	**Employee $20,000**	☐ Decline Coverage
	☐ Age 18-29 $3.46 per month	☐ Age 18-29 $5.40 per month	☐ Age 18-29 $7.34 per month	☐ Age 18-29 $9.28 per month	
	☐ Age 30-39 $4.95 per month	☐ Age 30-39 $8.38 per month	☐ Age 30-39 $11.82 per month	☐ Age 30-39 $15.25 per month	
	☐ Age 40-49 $8.44 per month	☐ Age 40-49 $15.36 per month	☐ Age 40-49 $22.28 per month	☐ Age 40-49 $29.19 per month	
	☐ Age 50-59 $15.30 per month	☐ Age 50-59 $29.09 per month	☐ Age 50-59 $42.87 per month	☐ Age 50-59 $56.66 per month	
	☐ Age 60+ $27.84 per month	☐ Age 60+ $54.15 per month	☐ Age 60+ $80.41 per month	☐ Age 60+ $106.78 per month	
	Spouse $5,000	**Spouse $7,500**	**Spouse $10,000**		
	☐ Age 18-29 $3.46 per month	☐ Age 18-29 $4.43 per month	☐ Age 18-29 $5.40 per month		
	☐ Age 30-39 $4.95 per month	☐ Age 30-39 $6.67 per month	☐ Age 30-39 $8.38 per month		
	☐ Age 40-49 $8.44 per month	☐ Age 40-49 $11.90 per month	☐ Age 40-49 $15.36 per month		
	☐ Age 50-59 $15.30 per month	☐ Age 50-59 $22.20 per month	☐ Age 50-59 $29.09 per month		
	☐ Age 60+ $27.84 per month	☐ Age 60+ $40.99 per month	☐ Age 60+ $54.15 per month		

DECLINE BENEFITS

☐ I acknowledge that I have been made aware of health insurance options offered by my employer, that meet the minimum essential coverage requirements. (Title 1, Sec 1512, 1513)

☐ I acknowledge that the Minimum Essential Coverage (MEC) benefit is NOT a major medical plan and that it only covers select preventative services.

Waiver (refusal of coverage): I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through Pinnacle and I proclaim that I was not pressured or forced by my employer, the writing agent, or any carrier representative into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I decline to apply for group coverage because of:

☐ **Spousal Coverage** ☐ **Individual Coverage** ☐ **Medicare Supplement** ☐ **Other:** _____

COMPLETE DECLINE ↑ OR ENROLL↓ BUT NOT BOTH!

ENROLL IN BENEFITS

☐ I acknowledge that I have been made aware of health insurance options offered by my employer, that meet the minimum essential coverage requirements. (Title 1, Sec 1512, 1513)

☐ I acknowledge that the Minimum Essential Coverage (MEC) benefit is NOT a major medical plan and that it only covers select preventative services.

Employee Signature - Required for enrollment and/or declination

Authorization/Acknowledgement: I hereby authorize those providing services to me, or my dependents, to release relevant information or medical records to this plan. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I understand that if I have made a material false statement, misrepresentation or omission on this form that changes the risk assumed by this plan I may lose coverage under this plan. I also understand that those who provide services to me under this plan are not agents, representatives or employees of this plan. I understand that my salary will be reduced in accordance to the plan guidelines if payroll deductions are necessary. Furthermore, I understand the explanation regarding my options under the Section 125 Cafeteria Plan. I understand that I have the right to have my employer redirect my salary and apply amounts towards the purchase of the benefits elected above. **I acknowledge that my pre-tax elections cannot be changed once the plan year of 08/01/19, to 07/31/20, has begun unless there is a change in Family Status. A change in family status includes (but is not necessarily limited to): changes in marital status, changes regarding dependents, changes in employment status, changes in residence or work site, changes in work schedule, or a dependent ceasing to satisfy the eligibility conditions for coverage.**

_____

Print Name (Last, First, Middle Initial)

_____

Signature **Date**