

# Master Plans

Consolidated Enrollment/Change

Plan Year - 08/01/22-07/31/23

**Effective Date:**

<b>Employee Name</b> (Last, First, Middle Initial)	<b>Social Security Number</b>	<b>Date of Birth</b>	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married
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<b>Address (Mailing)</b>	<b>Phone Number</b>	<b>Job Title / Occupation</b>	<b>Salary</b>
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<b>City, State and Zip</b>	<b>E-Mail Address</b>	<b>Gender:</b> M / F	<b>Weekly Hours</b>	<b>Date of Hire</b>
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<b>Enrollment</b> (Check One if it applies) <input type="checkbox"/> Open Enrollment Period <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> Acquisition	<b>Change</b> (Check One if it applies) <input type="checkbox"/> Change Address <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Cancel Dependent(s) <input type="checkbox"/> Waive/Dropping Coverage	<input type="checkbox"/> Change Name <input type="checkbox"/> Insurance Continuation	<b>Family Status Change</b> (Check One if it applies) <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Cancel Dependent(s) <input type="checkbox"/> Waive/Dropping Coverage
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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
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Self	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Spouse	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Child	M / F
<input type="checkbox"/> Enroll <input type="checkbox"/> Add <input type="checkbox"/> Change					Child	M / F

**\*\* MEDICAL \*\***

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

**\*\* DENTAL \*\***

<b>Cigna HMO</b>	<input type="checkbox"/> Employee Only \$19.73 per month	<input type="checkbox"/> Employee + Spouse \$52.65 per month	<input type="checkbox"/> Employee + Child(ren) \$52.65 per month	<input type="checkbox"/> Employee + Family \$52.65 per month	<input type="checkbox"/> 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.					
<b>MetLife PPO Low</b>	<input type="checkbox"/> Employee Only \$30.00 per month	<input type="checkbox"/> Employee + Spouse \$61.08 per month	<input type="checkbox"/> Employee + Child(ren) \$77.45 per month	<input type="checkbox"/> Employee + Family \$117.35 per month	
<b>MetLife PPO High</b>	<input type="checkbox"/> Employee Only \$39.58 per month	<input type="checkbox"/> Employee + Spouse \$80.49 per month	<input type="checkbox"/> Employee + Child(ren) \$98.52 per month	<input type="checkbox"/> Employee + Family \$150.37 per month	
<b>MetLife Premier</b>	<input type="checkbox"/> Employee Only \$53.00 per month	<input type="checkbox"/> Employee + Spouse \$107.77 per month	<input type="checkbox"/> Employee + Child(ren) \$131.91 per month	<input type="checkbox"/> Employee + Family \$201.34 per month	

Employee Name (Last, First, Middle Initial) \_\_\_\_\_

** VISION **					
<b>MetLife Low</b>	<input type="checkbox"/> Employee Only \$9.21 per month	<input type="checkbox"/> Employee + Spouse \$18.48 per month	<input type="checkbox"/> Employee + Child(ren) \$15.65 per month	<input type="checkbox"/> Employee + Family \$25.79 per month	<input type="checkbox"/> Decline Coverage
<b>MetLife High</b>	<input type="checkbox"/> Employee Only \$12.55 per month	<input type="checkbox"/> Employee + Spouse \$25.19 per month	<input type="checkbox"/> Employee + Child(ren) \$21.30 per month	<input type="checkbox"/> Employee + Family \$35.13 per month	

** VOLUNTARY LIFE/AD&D **			
Please refer to rate chart in Benefit Guide			
<b>MetLife</b>	<input type="checkbox"/> Elect <b>EMPLOYEE</b> Life Amount Equal to _____ <b>(You must also complete the MetLife enrollment form to secure this benefit.)</b>	Cost = _____	<input type="checkbox"/> Decline Coverage
<b>MetLife</b>	<input type="checkbox"/> Elect <b>SPOUSE</b> Life Amount Equal to _____ <b>(You must also complete the MetLife enrollment form to secure this benefit.)</b>	Cost = _____	
<b>MetLife</b>	<input type="checkbox"/> Elect <b>CHILD</b> Life Amount Equal to _____ <b>(You must also complete the MetLife enrollment form to secure this benefit.)</b>	Cost = _____	

** SHORT TERM DISABILITY **		
Please refer to rate chart in Benefit Guide		
<b>Aflac Disability</b>	<input type="checkbox"/> Elect Disability Monthly Benefit of _____	Cost = _____ <input type="checkbox"/> Decline Coverage

** ACCIDENT **				
<b>Aflac Accident</b>	<input type="checkbox"/> Employee Only \$13.07 per month	<input type="checkbox"/> Employee & Spouse \$22.71 per month	<input type="checkbox"/> Employee & Child(ren) \$31.40 per month	<input type="checkbox"/> Employee & Family \$41.04 per month <input type="checkbox"/> Decline Coverage

** HOSPITAL INDEMNITY **				
<b>Aflac Hospital</b>	<input type="checkbox"/> Employee Only \$37.16 per month	<input type="checkbox"/> Employee & Spouse \$73.26 per month	<input type="checkbox"/> Employee & Child(ren) \$62.84 per month	<input type="checkbox"/> Employee & Family \$98.94 per month <input type="checkbox"/> Decline Coverage

** CRITICAL ILLNESS **					
<b>Aflac Critical Illness</b>	<b>Employee \$5,000</b>	<b>Employee \$10,000</b>	<b>Employee \$15,000</b>	<b>Employee \$20,000</b>	<input type="checkbox"/> Decline Coverage
	Age 18-29 \$3.46 per month	<input type="checkbox"/> Age 18-29 \$5.40 per month	<input type="checkbox"/> Age 18-29 \$7.34 per month	<input type="checkbox"/> Age 18-29 \$9.28 per month	
	Age 30-39 \$4.95 per month	<input type="checkbox"/> Age 30-39 \$8.38 per month	<input type="checkbox"/> Age 30-39 \$11.82 per month	<input type="checkbox"/> Age 30-39 \$15.25 per month	
	Age 40-49 \$8.44 per month	<input type="checkbox"/> Age 40-49 \$15.36 per month	<input type="checkbox"/> Age 40-49 \$22.28 per month	<input type="checkbox"/> Age 40-49 \$29.19 per month	
	Age 50-59 \$15.30 per month	<input type="checkbox"/> Age 50-59 \$29.09 per month	<input type="checkbox"/> Age 50-59 \$42.87 per month	<input type="checkbox"/> Age 50-59 \$56.66 per month	
	Age 60+ \$27.84 per month	<input type="checkbox"/> Age 60+ \$54.15 per month	<input type="checkbox"/> Age 60+ \$80.41 per month	<input type="checkbox"/> Age 60+ \$106.78 per month	
	<b>Spouse \$5,000</b>	<b>Spouse \$7,500</b>	<b>Spouse \$10,000</b>		
	Age 18-29 \$3.46 per month	<input type="checkbox"/> Age 18-29 \$4.43 per month	<input type="checkbox"/> Age 18-29 \$5.40 per month		
	Age 30-39 \$4.95 per month	<input type="checkbox"/> Age 30-39 \$6.67 per month	<input type="checkbox"/> Age 30-39 \$8.38 per month		
	Age 40-49 \$8.44 per month	<input type="checkbox"/> Age 40-49 \$11.90 per month	<input type="checkbox"/> Age 40-49 \$15.36 per month		
	Age 50-59 \$15.30 per month	<input type="checkbox"/> Age 50-59 \$22.20 per month	<input type="checkbox"/> Age 50-59 \$29.09 per month		
	Age 60+ \$27.84 per month	<input type="checkbox"/> Age 60+ \$40.99 per month	<input type="checkbox"/> 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 08/01/22 to 07/31/23, 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