Employee Enrollment Form

Effective Date: _____

1) Employee Information:

Last Name:	
First Name:	
Social Security #:	
Birth Date:	
Gender:	
Address:	
City:	
State:	
Zip code:	
Home/Cell Phone:	
Marital Status:	o Single o Married o Divorced o Separated
Email Address:	
Primary Care Physician (PCP): (first and last name)	Current patient? o Yes o No | New patient? o Yes o No

Employment Status: (Employer Use Only)

Date of Hire: _____

Job Title: _____

Annual Salary: _____

Hours Per Week: _____

- o New Hire
- o Open Enrollment
- o Change
  - o Birth o Marriage o Divorce
  - o Adoption o Court Order o Address
- o Loss of Other Coverage
- o Termination
  - o Voluntary o Involuntary o Laid Off
  - o Death o Leave of Absence
- o Other: _____

2) Dependent Information: (Only list dependents if they are to be covered on your insurance)

	Full Name:	Gender:	Social Security #:	Birth Date:	Coverage:	Primary Care Physician (PCP):
Spouse:					o Medical o Dental o Vision	First and Last Name: Current patient? o Yes o No
Child 1:					o Medical o Dental o Vision	First and Last Name: Current patient? o Yes o No
Child 2:					o Medical o Dental o Vision	First and Last Name: Current patient? o Yes o No
Child 3:					o Medical o Dental o Vision	First and Last Name: Current patient? o Yes o No
Child 4:					o Medical o Dental o Vision	First and Last Name: Current patient? o Yes o No
Child 5:					o Medical o Dental o Vision	First and Last Name: Current patient? o Yes o No

Last Name _____ First Name _____

3) MEDICAL INSURANCE PRIORITY HEALTH — BI-WEEKLY COST:

- o Employee Only
- o Employee + 1 Dependent
- o Employee + Family

$_____
(see last page for your contribution amount)

- o I DECLINE Coverage — I am covered by: o Individual coverage o A spouse/parent o Medicare o No other coverage

4) HEALTH SAVINGS ACCOUNT (HSA): — BI-WEEKLY CONTRIBUTION:

Coverage Level:	Annual Maximum HSA Contribution:	Employer Annual HSA Contribution	Maximum Employee HSA Contribution (Per Pay):
Single	$3,500.00	$720.00	$106.92
Two Person	$7,000.00	$720.00	$241.53
Family	$7,000.00	$720.00	$241.53

- o I choose TO make contributions into my HSA
- o I choose NOT TO make contributions into my HSA

$ _____

5) DENTAL INSURANCE: DELTA DENTAL — BI-WEEKLY COST:

- o Employee Only: $ 4.44
- o Employee + One: $ 8.28
- o Employee + Family: $ 15.29
- o I DECLINE Coverage

6) VISION INSURANCE: UNUM — BI-WEEKLY COST:

- o Employee Only: $ 0.86
- o Employee + Spouse: $ 1.72
- o Employee + Child(ren): $ 1.91
- o Employee + Family: $ 2.98
- o I DECLINE Coverage

7) SHORT TERM DISABILITY INSURANCE: UNUM — BI-WEEKLY COST:

- þ You will automatically be enrolled in Short Term Disability — $ 0.00

8) BASIC LIFE / AD&D INSURANCE: UNUM — BI-WEEKLY COST:

- þ You will automatically be enrolled in Basic Life/AD&D — $ 0.00

Last Name _____ First Name _____

9) LIFE INSURANCE BENEFICIARY INFORMATION:

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you.

o Primary _____ %	Beneficiary (full Name):	Relationship:	Address:
	Social Security #:	Birth Date:	City, State & Zip:
o Primary o Contingent _____ %	Beneficiary (full Name):	Relationship:	Address:
	Social Security #:	Birth Date:	City, State & Zip:
o Primary o Contingent _____ %	Beneficiary (full Name):	Relationship:	Address:
	Social Security #:	Birth Date:	City, State & Zip:
o Primary o Contingent _____ %	Beneficiary (full Name):	Relationship:	Address:
	Social Security #:	Birth Date:	City, State & Zip:

10) Section 125 Pre-Tax Premium Conversion Plan:

An IRC Section 125 Premium Conversion Plan has been established, which allows employees to pay for their share of insurance premiums with pre-tax dollars through payroll deduction.
If you choose to enroll in the Premium Conversion Plan when initially eligible, your participation in the plan will automatically renew *unless you sign a form choosing NOT to participate.*

Your election to pay your insurance premiums with pre-tax dollars saves you money and is generally a good financial decision. Please note, however, that pre-tax insurance elections CANNOT be changed during the plan year and will remain the same until the next open enrollment period, at which time you can change your election. However, an insurance election change may be made if you have a Qualified Status Change.

Carefully consider the irrevocable nature of pre-tax elections when deciding whether to pay for your share of insurance premiums with pre-tax or after-tax dollars. If you anticipate needing to change your insurance elections during the plan year for any reason other than a Qualified Status Change listed above, you should consider declining participation in the Premium Conversion Plan and paying your share of medical, dental and vision insurance with after-tax dollars.

- o I Choose PRE-TAX Employee Contributions
- o I Choose AFTER-TAX Employee Contributions

Qualified Status Changes:

- Marriage
- Divorce
- Birth or adoption of a child
- Change in employment status
- Change in coverage under a plan of the employer of an employee's spouse or dependent (i.e. Spouse's Open Enrollment). *Exception: No changes to Flexible Spending Account elections may be made mid-year.*
- Enrollment in individual health coverage during the Marketplace Annual Open Enrollment.

Last Name _____ First Name _____

11) authorization:

DISCLAIMER: I understand that any person who knowingly files a statement of claim for an individual who does not qualify as an eligible dependent or otherwise containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and subject to civil penalties.

I hereby certify that the information listed above is correct to the best of my knowledge. I agree to notify the plan administrator if and when there is a change in my dependent's status. If I am required to contribute to the premium or any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due to me, for remittance to the appropriate insurance company. I hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, or physician to release all information to the appropriate parties as deemed necessary with respect to me or any of my dependents which may have a bearing on the benefits payable under this plan or any plan providing benefits or services. If applicable, I designate the beneficiary named on this form to receive the proceeds, if any, payable on my death. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature: X _____ Date Signed: _____

The Grand Rapids Red Project Rates for PriorityHMO HSA Silver $2000		
Age Band	Total Monthly Premium	Employee Bi-Weekly Cost
0-14	$175.48	$24.30
15	$191.08	$26.46
16	$197.05	$27.28
17	$203.01	$28.11
18	$209.43	$29.00
19	$215.86	$29.89
20	$222.51	$30.81
21	$229.39	$31.76
22	$229.39	$31.76
23	$229.39	$31.76
24	$229.39	$31.76
25	$230.31	$31.89
26	$234.90	$32.52
27	$240.40	$33.29
28	$249.35	$34.52
29	$256.69	$35.54
30	$260.36	$36.05
31	$265.86	$36.81
32	$271.37	$37.57
33	$274.81	$38.05
34	$278.48	$38.56
35	$280.31	$38.81
36	$282.15	$39.07
37	$283.98	$39.32
38	$285.82	$39.58
39	$289.49	$40.08
40	$293.16	$40.59
41	$298.67	$41.35
42	$303.94	$42.08
43	$311.28	$43.10
44	$320.46	$44.37
45	$331.24	$45.86
46	$344.09	$47.64
47	$358.54	$49.64
48	$375.05	$51.93
49	$391.34	$54.19
50	$409.69	$56.73
51	$427.81	$59.24
52	$447.77	$62.00
53	$467.96	$64.79
54	$489.75	$67.81
55	$511.54	$70.83
56	$535.17	$74.10
57	$559.02	$77.40
58	$584.49	$80.93
59	$597.10	$82.68
60	$622.56	$86.20
61	$644.59	$89.25
62	$659.04	$91.25
63	$677.16	$93.76
64	$688.17	$95.29
65+	$688.17	$95.29

Calculating Your Medical Cost:

The Grand Rapids Red Project pays 70% for employees and dependents.
Employees pay 30% of the age rate on a bi-weekly basis.

To calculate your cost per pay period, find the EMPLOYEE Bi-WEEKLY COST in the gray column that corresponds to your age and the age of any dependents you wish to cover and write it on the lines below.

Please keep in mind that the rates will be based on age as of 10/1/2019.

Employee's Age: _____ Rate: _____

Spouse's Age: _____ Rate: _____

1 Child's Age: _____ Rate: _____

2 Child's Age: _____ Rate: _____

3 Child's Age: _____ Rate: _____

4 Child's Age: _____ Rate: _____

5 Child's Age: _____ Rate: _____

6 Child's Age: _____ Rate: _____

*If you have more than 3 children *under the age of 21*,
you will only be charged the cost for 3 children.

Add the rates of all members (including yourself).
This is your bi-weekly cost

Total Cost: