GLENCOE

Employee Benefits Enrollment and Change Form
Variable Hour Employee
(Arizona)

Effective Date: _____ Employee #: _____

Type of Enrollment: ☐ Open Enrollment ☐ New Hire ☐ Promotion ☐ Life Event Date of Event: _____

A. Employee Information

This section is required for all employees

Employee Name: _____
Last Name First Name M.I.

Social Security #: _____ Birth Date: _____ Gender: ☐ Male ☐ Female

Address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Job Title: _____ Hire Date: _____ Phone #: _____

Promotion Date (if applicable): _____ Status: ☐ Hourly ☐ Salary

☐ Check here to keep your current elected benefits with **no** changes- (then sign the bottom of 2nd page)

B. Waiver of Coverage

Complete this section ONLY if you are waiving employer-offered coverage

I am Decline coverage for: ☐ Myself ☐ Spouse ☐ Child(ren) -or- ☐ Myself and all Eligible Family Members

Reason for declining: ☐ Medicare/Medicaid ☐ COBRA ☐ Self-Insured ☐ Covered under Spouse plan ☐ VA Eligible

☐ Other Coverage: _____ ☐ I (we) do not have other coverage at this time.

I understand that by waiving coverage at this time, I will not be allowed to participate in the employer-provided health insurance unless I experience a Qualifying Life Event or at the next Open Enrollment Period.

Employee Signature: _____ Date: _____

C. Coverage Selected

Complete this section if you are electing employer offered coverage

Medical- Please choose your plan option and level of coverage:

HSA Plan Option		**PPO Plan Option**	
☐ HSA 5000/10 Plan 24E		☐ PPO Blue Secure Plan BS11	
☐ Employee Only	**$ 55.00**	☐ Employee Only	**$ 105.00**
☐ + Spouse	**$ 148.00**	☐ + Spouse	**$ 198.50**
☐ + Child(ren)	**$ 140.00**	☐ + Child(ren)	**$ 187.50**
☐ Family	**$ 220.00**	☐ Family	**$ 317.00**

Employee Cost: The amount(s) above are pre-tax and will be deducted per pay period. If you wish to opt-out of pre-tax, please contact Human Resources.

E. Spouse and Dependent Information

Only include dependents that will be covered under the Plan

☐ Add ☐ Change ☐ Cancel	Spouse/Domestic partner last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ If Domestic Partner, please provide court registered documentation			Relationship ☐ Spouse ☐ Domestic partner		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth
☐ Add ☐ Change ☐ Cancel	Dependent last name	First Name	M.I.	Gender ☐ Male ☐ Female	Social Security #
☐ Over-age Mentally/Physically Disabled Dependent (Must sign Over-age Dependent Affidavit) ☐ Court Ordered Health Care Coverage (Attach copy of court order)			Relationship ☐ Child ☐ Other:		Date of Birth

F. Signature

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between the chosen insurance carrier and me.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry. description of Special enrollments, if you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility under the state child health insurance program or state Medicaid plan. However, you must request enrollment within 60 days: (1) after the date the coverage under a state child health insurance program or a state Medicaid plan ends; or (2) after the date you become eligible for state premium assistance for group coverage.

In addition, if you have a new dependent as a result of marriage/registered domestic partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage/registered domestic partnership, birth, adoption or placement for adoption. To request special enrollment, submit a completed application to the main office of Glencoe Management, Inc., and it will be routed to the insurance carrier.

I hereby agree to have benefit premiums deducted from my paycheck on a pre-tax basis in accordance with the company's payroll schedule.

Employee Signature: ______________________________ Date: ______________