HEALTHEZ

Benefit Enrollment / Change Form

Employee	**First Name:**	**M.I.**	**Last Name:**	**SSN:**	**Gender:** ☐ Male ☐ Female
	Mailing/Street Address:	**Apt./Ste.**	**City:**	**State:**	**Zip Code:**
	Birth Date:	**Hire Date:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced	**Phone Number:**	**Email:**

Enrollment	**Enrollment Type:**	☐ New Hire	☐ Open Enrollment	☐ Qualifying Event	☐ Decline (*See Decline Section*)
	Qualifying Event Type: (*If applicable*)	☐ Marriage / Divorce	☐ Birth / Death	☐ Court Order	
		☐ Loss of Coverage	☐ Reduction in Hours	☐ Change Name / Address	
		☐ COBRA	☐ Other _____		

Medical	**Medical Plan Election:**	☐ $750 Copay Plan	☐ $1,750 Copay Plan	☐ HSA Plan	☐ Decline
	Medical Plan Coverage:	☐ Employee Only	☐ Employee + Child(ren)	☐ Employee + Spouse	☐ Family

Dependents	**Name**	**SSN**	**Relationship**	**DOB**	**Sex (M/F)**	**Disabled (Y/N)**	**Include on Plan**
							☐
							☐
							☐
							☐

HSA Election

☐ Yes, I would like to set up a Health Savings Account (This option is available if you enroll in the HSA plan). Your annual deduction will be divided into equal amounts and deducted from each pay period throughout the year.

I elect to have an ANNUAL deduction of $_____ (maximum of $3,500 for employee-only coverage, or $7,000 for all other levels of coverage) reduced from my salary before taxes to reimburse me for qualified expenses which I incur during the plan year. Maximum contribution to the HSA Plan will be reduced by company contribution. Employees who are age 55 or older can make a catch-up contribution of $1,000 in addition to IRS maximums.

Decline

☐ I understand the benefits provided by the Group Insurance Contract under ERISA regulations include Health and/or Dental coverages. I have reviewed and understand the benefit options and requirements presented herein. I understand that I may not be eligible to enroll myself and dependents if I desire to apply for coverage at a later date, unless I qualify to enroll at a later date in accordance with the special enrollment conditions.

Other Insurance	**☐ I do not have other insurance coverage**	**☐ I have enrolled thru the state or federal Marketplace**
	☐ I have other insurance coverage	**☐ I have other insurance coverage, but intend to cancel that coverage**
	Policy Holder Name:	**Policy Holder Date of Birth:**
	Insurance Company Name:	**Insurance Company Address:**
	Policy Number:	**Group Number:**
	Names of Covered Individuals:	

Employee Authorization

☐ I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease. I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

☐ To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

_____ _____

Employee Signature Date