ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.

Group ID:	Class:	Billing Division or Location:
MT00623	**AAFTE**	

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name:	Employer ZIP:	State:
West Carroll Health Systems, LLC	**71263**	**LA**

Employee First Name / Middle Initial / Last Name:	Social Security Number:	Date of Birth:

Street Address:	City:	State:	Zip:

Gender:	Phone:	Email Address:

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Earnings:	Full-Time Employment Date:

Product Selection (Complete for ALL Enrollments)

Class	Type of Coverage	Amount of coverage	Premium
All Active Full Time Employees	**Basic Life ☒Yes ☐No***	**$10,000**	**Employer Paid**

Product Selection (Complete for ALL Enrollments)

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Bi-Weekly Premium
Medical – West Carroll Health Systems Medical Provided By: Insurance Systems	☐**Yes** ☐**No***	☐**Employee Only** ☐**Employee and Spouse** ☐**Employee and Child(ren)** ☐**Employee/Spouse/Children**	**$65.97** **$344.24** **$277.42** **$610.20**
Voluntary Dental Provided By: Equitable	☐**Yes** ☐**No***	☐**Employee Only** ☐**Employee and Spouse** ☐**Employee and Child(ren)** ☐**Employee/Spouse/Children**	**$17.87** **$27.61** **$36.53** **$46.27**
Voluntary Vision Provided By: Equitable	☐**Yes** ☐**No***	☐**Employee Only** ☐**Employee and Spouse** ☐**Employee and Child(ren)** ☐**Employee/Spouse/Children**	**$3.04** **$6.09** **$6.51** **$10.41**
Voluntary Short-Term Disability 60% salary up to max $1,000 Provided By: Equitable	☐**Yes** ☐**No***	**Weekly Benefit:** ☐ **60% of salary**	**Age Rated**
Voluntary Long-Term Disability 60% salary up to max $6,000 Provided By: Equitable	☐**Yes** ☐**No***	**Monthly Benefit:** ☐ **60% of salary**	**Age Rated**

Voluntary Employee Life/AD&D Provided By: Equitable	☐ **Yes** ☐ **No*** **Guarantee Issue $250,000** **Age Reduction: 33% at age 70**	☐ **$20,000** ☐ **$50,000** ☐ **$80,000** ☐ **$100,000** ☐ **Other Amount _____**	**Age Rated**
Voluntary Spouse Life/AD&D Spouse amount **cannot** exceed 50% of the employees elected amount. *Rates and age deductions are based on Employee's Age Provided By: Equitable	☐ **Yes** ☐ **No*** **Guarantee Issue $150,000** **Age Reduction: 33% at age 70**	☐ **$10,000** ☐ **$25,000** ☐ **$40,000** ☐ **$50,000** ☐ **Other Amount _____**	**Age Rated – Employee Age**
Voluntary Child Life/AD&D *Children to age 26 Provided By: Equitable	☐ **Yes** ☐ **No***	☐ **$10,000**	**$0.60**

*By selecting no, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense

-- Actual deductions may vary slightly from above illustration due to rounding –

Dependent Information (Complete for Dependent Coverage)

	Last Name	First Name	Social Security Number	Gender	Date of Birth
Spouse:					
Children:					

Beneficiary Information (Complete for Basic Life/AD&D and Voluntary Life/AD&D Enrollments)

Primary Beneficiary's Last Name, First, MI:	Relationship of Beneficiary:	□□□ne □um□er:
Street Address:	City:	State: Zip:
Contingent Beneficiary's Last Name, First, MI:	Relationship of Beneficiary:	□□□ne □um□er:
Street Address:	City:	State: Zip:

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature Section:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name: _____

Employee Signature: _____ **Date:** _____

WEST CARROLL HEALTH SYSTEM
EMPLOYEE BENEFITS ENROLLMENT FORM

A. Employee Information (Please Print)

Division:_____ Social Security Number:_____

Employee Name:_____

Address:_____

City: _____ State:_____ Zip:_____ Date of Birth:_____

☐ Male ☐ Female ☐ Married ☐ Single Home Phone:_____ Work Phone: _____

Date of Hire:_____ Benefits Eligibility Date:_____ Effective Date of Coverage:_____

B. Dependent Information (Complete for ALL Dependents Covered)

Dependent Name	Relationship	Social Security No.	Coverage	Sex	Date of Birth
Dependent Children are eligible for Medical until the end of the month in which they turn age 26. Spouse's that are eligible for coverage through their employer are not eligible for coverage under West Carroll Heath Systems' Medical Plan.					
	Spouse		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		
	Child		☐ Medical		

C. Medicare Coverage Designation

Employees that cover dependents and become eligible for Medicare while enrolled may opt to disenroll from the health plan and enroll in Medicare. By signing below, the Employee verifies that he/she is Medicare eligible, and that his/her dependents are not eligible for any other coverage. The Employee also agrees to maintain coverage on his/her dependent(s) at the rate specified below.

Employee's Signature _____ Date _____

D. Premiums * (Bi-Weekly - 26 Pay Periods)

☐ **Employee Only $65.97** ☐ **Emp + Spouse $344.24** ☐ **Emp + Child(ren) $277.42** ☐ **Family $610.20**

I certify the above information to be true to the best of my knowledge and that the children for whom I am enrolling either reside with me in a parent-child relationship or are legally dependent on me for their support. I further understand that the Health Plan deductions will be deducted before taxes and will be in effect for the entire plan year and cannot be revoked except as permitted by federal law.

Signature _____ Date _____

Waiver of Group Health Benefits &
Notice of Special Enrollment Rights

I am waiving my employer's group health coverage due to:

- ○ My preference not to have coverage:
- ○ Coverage under my spouse's plan – name of carrier: _____
- ○ Other coverage – name of carrier:_____

This other coverage is:

- ○ Individual
- ○ COBRA
- ○ Medicare
- ○ TRICARE (formerly CHAMPUS)
- ○ Medicaid
- ○ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage.*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have an eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature **Date**