COMMUNITY ACCESS UNLIMITED

Employee Number

ENROLLMENT/CHANGE FORM

Benefits Effective Date: **Date of Hire:**

- ☐ New Hire Enrollment
- ☐ No Change in Enrollment
- ☐ Add Dependent
- ☐ Termination:
- ☐ Plan Change
  - ☐ Medical
  - ☐ Dental

Employee Information

Last Name First Name MI

Male ☐ Female ☐

Social Security #: Date of Birth:

Single ☐ Married ☐

Date of Marriage:

Street Address Apt # City State Zip

Phone: Position: Salary:

Hourly / Annual (circle one)

Benefit Elections

- **MEDICAL Plan Options: (Choose One)** aetna

Aetna HIGH PLAN Bi-Weekly Payroll Deductions

- ☐ Employee Only.....$54.54
- ☐ Employee Plus Child(ren).....$157.56
- ☐ Employee Plus Spouse.....$196.95
- ☐ Employee Plus Family.....$281.79

Aetna BASIC PLAN Bi-Weekly Payroll Deductions

- ☐ Employee Only..... $0.00
- ☐ Employee Plus Child(ren)..... $41.25
- ☐ Employee Plus Spouse.....$55.00
- ☐ Employee Plus Family.....$82.50

- **DENTAL Plan Options: (Choose One)**

Aetna PPO PLAN Bi-Weekly Payroll Deductions

- ❑ Employee Only.....$0.00
- ❑ Employee Plus Child(ren).....$0.00
- ❑ Employee Plus Spouse.....$0.00
- ❑ Employee Plus Family.....$0.00

Delta DPPO Copay 6 PLAN Bi-Weekly Payroll Deductions

- ❑ Employee Only.....$0.00
- ❑ Employee Plus Child(ren).....$0.00
- ❑ Employee Plus Spouse.....$0.00
- ❑ Employee Plus Family.....$0.00

Both the Aetna PPO and Delta DPPO Copay 6 Plans are **100% Employer-Paid. There is No Cost to the Employee or Dependents.

- **EMPLOYEE LIFE/ACCIDENTAL DEATH & DISMEMBERMENT (AD&D):**

❑ 1.5 Times Base Salary to a Maximum of $200,000 **(100% Employer-Paid)**

Beneficiary Designation(s):

Last Name	First Name	MI	Relationship	%	Primary/Secondary

If Required, Please Attach a Separate Sheet of Paper for Additional Dependents.
Note: Multiple Beneficiaries Will Be Considered Equal Unless Designated as Primary or Secondary.

Dependent(s) To Be Covered

❶ Spouse:

Male ❑ Female ❑
Medical ❑ Dental ❑

Last Name First Name MI

Social Security #: _____ Date of Birth: _____

(**Note:** Dependent Children are covered up to age 26 on the Medical & Dental Plans)

❷ Child:

Male ❑ Female ❑
Medical ❑ Dental ❑

Last Name First Name MI

Social Security #: _____ Date of Birth: _____

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❸ Child:

Male ❑ Female ❑
Medical ❑ Dental ❑

Last Name First Name MI

Social Security #: _____ Date of Birth: _____

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❹ Child:

Male ❑ Female ❑
Medical ❑ Dental ❑

Last Name First Name MI

Social Security #: _____ Date of Birth: _____

Employee Signature/Authorization

By my signing below, I authorize the required payroll deductions for contributory benefits. I understand that by signing and submitting this form, I am making a binding election for my benefits and pay for the plan year. I also understand that I may not change my elections until the next plan year enrollment period unless I have a ***"Qualifying Event."*** I also represent that all information shown on this application is correct.

Employee Signature: _____ **Date:** _____

NOTE: Employees will ONLY be permitted to change an election during the plan year if they experience a "Qualifying Event."

"Qualifying Events" include birth, marriage, divorce, change in number of dependents, or loss of other medical coverage through a spouse's plan. If you have a "Qualifying Event", the benefit changes must be made within 30 days of the event, and will be effective the date of the event.

I understand if I select dependent coverage it is required that I supply Human Resources with copies of the Social Security Cards, Birth Certificates and Marriage Certificates for each covered dependent. I understand that coverage for these dependents will not be available without these documents and I will be enrolled with Employee Only coverage.

Employee Signature: _____ **Date:** _____

Employer Signature: _____ **Date:** _____