

Yavapai Community College 2009 – 2010 Benefits Elections Form

Effective Date _____

Check applicable: Open Enrollment Address Change Name Change Beneficiary Change Mid-Year Enrollment Change New Hire: Date of Hire _____
 If you are a new hire, you must provide a HIPAA Certificate of Creditable Coverage from your previous employer to verify prior group coverage.

EMPLOYEE INFORMATION – PLEASE PRINT

NAME _____ M F SSN _____
LAST FIRST MI GENDER

STREET ADDRESS CHECK HERE IF NEW _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ WORK TELEPHONE _____ E-MAIL _____

DATE OF BIRTH _____ MARITAL STATUS: ___ SINGLE ___ MARRIED DATE OF HIRE: _____

MID-YEAR ENROLLMENT CHANGES – CHECK ALL THAT APPLY

FAMILY STATUS EVENTS – Date of Event: _____

- Marriage – copy of marriage certificate required
- Divorce or Legal Separation – copy of court papers required
- Birth or Adoption – copy of birth certificate or adoption paperwork required
- Child requires coverage due to QMCSO – copy of child support order required
- Loss of child's eligibility (marries or reaches maximum age) – proof of loss or gain of insurance required
- Death – copy of death certificate required
- Covered person has become entitled to Medicare – proof of Medicare eligibility required

You must return your completed enrollment form to the HR Department within 31 days of the status event or you will have to wait until the next open enrollment for your change to be effective (7/2010).

EMPLOYMENT STATUS EVENTS – Date of Event: _____

- Spouse eligible for benefits in another plan – proof of gain of insurance required
- Spouse loses employment or becomes ineligible for health benefits – proof of loss or gain of insurance required

PLAN ELECTIONS AND MONTHLY COST – EMPLOYEE AND DEPENDENTS MUST ENROLL IN THE SAME PLAN

MEDICAL	PREMIER PLAN	BASIC PLUS PLAN	
WAIVE COVERAGE* <input type="checkbox"/> \$0	<input type="checkbox"/> \$0	<input type="checkbox"/> \$0	Enter total monthly cost from your benefit elections on the left: \$ _____
EMPLOYEE ONLY <input type="checkbox"/> \$0	<input type="checkbox"/> \$0	<input type="checkbox"/> \$0	To get your per pay period salary reduction, divide by 2
EMPLOYEE + FAMILY <input type="checkbox"/> \$444	<input type="checkbox"/> \$444	<input type="checkbox"/> \$33	(number of pay periods per month). If less than zero, enter zero. \$ _____

DENTAL	COMPREHENSIVE	PREVENTATIVE	
WAIVE COVERAGE* <input type="checkbox"/> \$0	<input type="checkbox"/> \$0	<input type="checkbox"/> \$0	NOTE: If you elect dependent coverage, premiums will be deducted one month in advance.
EMPLOYEE ONLY <input type="checkbox"/> \$0	<input type="checkbox"/> \$0	<input type="checkbox"/> \$0	Benefit contributions will be deducted from your pay on a pre-tax basis unless you choose to pay for your benefits on an after-tax basis below.
EMPLOYEE + FAMILY <input type="checkbox"/> \$60	<input type="checkbox"/> \$60	<input type="checkbox"/> \$0	<input type="checkbox"/> I decline the pre-tax (salary reduction) and choose to have my contributions set up on an after-tax (salary deduction) basis.

VISION	
WAIVE COVERAGE* <input type="checkbox"/> \$0	
EMPLOYEE ONLY <input type="checkbox"/> \$0	
EMPLOYEE + FAMILY <input type="checkbox"/> \$15	

*** To waive medical coverage, you must have other GROUP coverage and attach a copy of the medical ID card reflecting your name.**

DEPENDENT INFORMATION – INCLUDE EACH DEPENDENT (SPOUSE AND/OR CHILD) YOU ARE COVERING FOR MEDICAL, DENTAL, OR VISION.

NAME <small>LAST, FIRST, MI</small>	DATE OF BIRTH <small>(MM/DD/YYYY)</small>	SSN	GENDER	ACTION
			<small>M F</small>	<small><input type="checkbox"/> ADD <input type="checkbox"/> DELETE <input type="checkbox"/> CHANGE</small>
			<small>M F</small>	<small><input type="checkbox"/> ADD <input type="checkbox"/> DELETE <input type="checkbox"/> CHANGE</small>
			<small>M F</small>	<small><input type="checkbox"/> ADD <input type="checkbox"/> DELETE <input type="checkbox"/> CHANGE</small>
			<small>M F</small>	<small><input type="checkbox"/> ADD <input type="checkbox"/> DELETE <input type="checkbox"/> CHANGE</small>
			<small>M F</small>	<small><input type="checkbox"/> ADD <input type="checkbox"/> DELETE <input type="checkbox"/> CHANGE</small>
			<small>M F</small>	<small><input type="checkbox"/> ADD <input type="checkbox"/> DELETE <input type="checkbox"/> CHANGE</small>

LIST ANY ADDITIONAL DEPENDENTS ON A SEPARATE PIECE OF PAPER

Please complete the information on the back of this form.

OTHER CREDITABLE COVERAGE – COMPLETE THIS SECTION IF YOU OR YOUR DEPENDENTS ARE COVERED UNDER ANOTHER GROUP MEDICAL PLAN

EMPLOYEE:

CHECK ALL THAT APPLY: MEDICAL DENTAL VISION

NAME OF POLICY HOLDER: _____ POLICY NAME (INSURANCE CARRIER) _____

POLICY NUMBER _____ EFFECTIVE DATE _____ TERMINATION DATE: _____

FAMILY MEMBERS COVERED UNDER THIS INSURANCE (CHECK ALL THAT APPLY) EMPLOYEE SPOUSE EMPLOYEE + FAMILY FAMILY ONLY

SPOUSE:

CHECK ALL THAT APPLY: MEDICAL DENTAL VISION

NAME OF POLICY HOLDER: _____ POLICY NAME (INSURANCE CARRIER) _____

POLICY NUMBER _____ EFFECTIVE DATE _____ TERMINATION DATE: _____

SPOUSE EMPLOYED YES NO ACTIVE PLAN YES NO RETIREE PLAN YES NO

FAMILY MEMBERS COVERED UNDER THIS INSURANCE (CHECK ALL THAT APPLY) EMPLOYEE SPOUSE EMPLOYEE + FAMILY FAMILY ONLY

CHILD(REN):

CHECK ALL THAT APPLY: MEDICAL DENTAL VISION

If dependent children listed on the front side of this form have other coverage, please answer the following questions:

IS ANYONE LEGALLY RESPONSIBLE TO COVER THE CHILDREN? YES NO

NAME OF POLICY HOLDER: _____ POLICY NAME (INSURANCE CARRIER) _____

DATE OF BIRTH OF THE POLICY HOLDER _____ EFFECTIVE DATE _____ TERMINATION DATE: _____

SPOUSE EMPLOYED YES NO ACTIVE PLAN YES NO RETIREE PLAN YES NO

FAMILY MEMBERS COVERED UNDER THIS INSURANCE (CHECK ALL THAT APPLY) EMPLOYEE SPOUSE EMPLOYEE + FAMILY FAMILY ONLY

BENEFICIARY INFORMATION

Under **Primary Beneficiaries**, print your first choice(s) to receive benefits from your basic life and AD&D insurance. Contingent Beneficiaries receive benefits if no primary beneficiaries are living when benefits become payable. List any additional beneficiaries on a separate sheet of paper. Basic life/AD&D insurance only is effective upon your date of hire.

PRIMARY BENEFICIARIES

NAME	RELATIONSHIP TO YOU	SOCIAL SECURITY #	PERCENTAGE OF SHARE

CONTINGENT BENEFICIARIES

NAME	RELATIONSHIP TO YOU	SOCIAL SECURITY #	PERCENTAGE OF SHARE

SIGNATURE

EMPLOYEE SIGNATURE _____

DATE _____

All of the statements I have made on this form are true and accurate to the best of my knowledge. I understand the benefit choices I have made and authorize the Employer to make any payroll deductions required to pay for my benefit choices. I understand that any pre-tax (salary reduction) choices I have made on this form will remain in effect until the next open enrollment unless I have a qualified family status change (i.e. Marriage, divorce, death, birth/adoption of dependent, or change in employment status of spouse or dependent) as defined by federal law with regard to my elections.

Please return this completed form to the Human Resources Department before your enrollment deadline.