Yavapai Community College 2019 – 2020 Benefits Elections Form

Y#_____

Check applicable: ◯ *New Hire* ◯ *Open Enrollment* ◯ *Address Change* ◯ *Name Change* ◯ *Beneficiary Change* ◯ *Mid-Year Enrollment Change*

You are required to submit a copy of a marriage certificate and/or a birth certificate for each dependent that you enroll in the medical plan.

EMPLOYEE INFORMATION – PLEASE PRINT

NAME _____ ◯M ◯F SSN _____
LAST FIRST MI GENDER

MAILING ADDRESS CHECK HERE IF NEW ☐ _____ CITY _____ STATE ____ ZIP _____

TELEPHONE _____ WORK TELEPHONE _____ E-MAIL _____

DATE OF BIRTH(mm/dd/yyyy)_____ MARITAL STATUS: ◯ SINGLE ◯ MARRIED DATE OF HIRE (mm/dd/yyyy)_____

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 and adoption paperwork required*
- ◯ Change of coverage due to QMCSO – *copy of child support order required*
- ◯ Loss of child's eligibility (reaches maximum age of 23 for dental or 26 for medical coverage)
- ◯ Death – *copy of death certificate required*
- ◯ Covered person has become entitled to other medical – *ID # required* _____

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*

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 (7/1/2020).

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

If married and covering dependent children, does your spouse work for a YCT entity? ◯YES ◯NO

If yes, list spouse name and entity _____

MEDICAL	PREMIER PLAN	BASIC PLUS PLAN	HDHP
EMPLOYEE ONLY	◯ $45	◯ $0	◯ $0 *
EMPLOYEE + FAMILY	◯ $554	◯ $170	◯ $328
WAIVE COVERAGE	◯ $0		

DENTAL	COMPREHENSIVE	PREVENTATIVE
EMPLOYEE ONLY	◯ $5	◯ $0
EMPLOYEE + FAMILY	◯ $44	◯ $0
WAIVE COVERAGE	◯ $0	

VISION	
EMPLOYEE ONLY	◯ $5
EMPLOYEE + FAMILY	◯ $17
WAIVE COVERAGE	◯ $0

OPTIONAL
Enter total monthly cost from your benefit elections from the left: $_____

OPTIONAL
To get your per pay period salary reduction, divide by 2 (number of pay periods per month).
If less than zero, enter zero. $_____

* If you choose the HDHP **Employee Only** option, Yavapai Community College will contribute $122 per month into your Health Savings Account (HSA).

DEPENDENT INFORMATION – INCLUDE EACH DEPENDENT (SPOUSE AND/OR CHILD) RELATIONSHIP DOCUMENTATION REQUIRED.

NAME LAST, FIRST, MI	RELATIONSHIP TO YOU	DATE OF BIRTH (MM/DD/YYYY)	SSN Required for all dependents	GENDER	ACTION
				◯M ◯F	◯ADD ◯DELETE ◯CHANGE
				◯M ◯F	◯ADD ◯DELETE ◯CHANGE
				◯M ◯F	◯ADD ◯DELETE ◯CHANGE
				◯M ◯F	◯ADD ◯DELETE ◯CHANGE
				◯M ◯F	◯ADD ◯DELETE ◯CHANGE

LIST ANY ADDITIONAL DEPENDENTS ON A SEPARATE PIECE OF PAPER

Please complete the information on the back of this form.

You must complete and sign the back of this form even if you are waiving coverage.

OTHER CREDITABLE COVERAGE – COMPLETE THIS SECTION IF YOU OR YOUR DEPENDENTS ARE ENTITLED TO BENEFITS UNDER ANOTHER HEALTH PLAN

Is your spouse an employee of Yavapai College? ◯ YES ◯ NO

Are you or any of your dependents enrolled in any other health Plan? ◯ YES ◯ NO

NAME OF INSURED:_____

INSURANCE COMPANY:_____ INSURANCE COMPANY PHONE: _____

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 or Charitable Agency	***RELATIONSHIP TO YOU***	***SOCIAL SECURITY #*** *or Tax ID#*	***PERCENTAGE OF SHARE***

CONTINGENT BENEFICIARIES

NAME	***RELATIONSHIP TO YOU***	***SOCIAL SECURITY #***	***PERCENTAGE OF SHARE***

SIGNATURE

◯ ACCEPTANCE OF MEDICAL COVERAGE

OR

◯ WAIVING MEDICAL COVERAGE

I understand that by waiving coverage, I am declining the opportunity to enroll in my employer's medical plan coverage that is both affordable and valuable under the current standards of the Affordable Care Act.

- *I understand that without a qualifying mid-year change event, I will not be permitted to enroll in my employer's medical plan options again until the next annual open enrollment time.*
- *I also understand that without medical plan coverage I (and my dependents, if any) could have a penalty applied when I file my personal income taxes.*

X _____

EMPLOYEE SIGNATURE ***DATE*** *(mm/dd/yyyy)*

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.

Reset **Print** **Save**

(Erases all fields in the Form)

SECURE UPLOAD SITE

To upload your form: 1) eSign the form (you will need to save the form to do this); 2) click on the Secure Upload Site button and follow the directions to attach and submit your form (forms will go to Human Resources, document type Benefit Elections Form); 3) Print a copy for your records

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

HR Use Only: Last_____ First _____ MI _____ Annual Salary: $ _____ TPA entered: _____

Effective Date:_____