

HR USE ONLY:
 Annual Salary: _____
 New Hire
 Full-Time (40 hours/week)
 Part-Time (25<40 hours/week)
 Part-Time (20<25 hours/week)
 Family Status Change:
 Event: _____
 Date: _____



Child Development Services

Benefit Plan Enrollment Form

July 1, 2011 Plan Year

INSTRUCTIONS:
 1. Employee must complete all parts of this form.
 2. Please print & complete in ink.
 3. Form must be signed & dated for coverage to be effective.
 4. You must initial where indicated when waiving coverage.

Social Security #: _____ Date of Birth: _____ Date of Hire: _____
 Last Name: _____ First Name: _____ MI: _____
 Address: _____ Sex: Male Female
 City, State, Zip: _____ Marital Status: Single Married
 Telephone: _____ Divorced
 Location: _____

PART I: MEDICAL COVERAGE - HEALTH PLANS INC Premium Deduction- Pre-Tax Post-Tax
 (Premiums for Domestic Partners are not eligible for Pre-Tax Benefits)

I elect Medical Coverage for:
 Employee Only Employee & Domestic Partner (Post Tax)
 Employee & Child(ren) Employee/Domestic Partner/Child(ren)
 Employee & Spouse **Note: Premiums for Domestic Partners Must be Post-Tax**
 I do not want Medical Coverage _____ Initials Family

OTHER INSURANCE INFORMATION

Do you have other Medical insurance? Yes No Does your Spouse/Domestic Partner or Child(ren)? Yes No
 If Yes: Name, address, & telephone number of Medical Insurance Company : _____
 Name, address & telephone number of Policy holder _____
 Effective Date of Coverage: _____ End Date _____ Policy Number _____

EMPLOYEE AND DEPENDENT INFORMATION - MEDICAL

List Dependents To be Covered:	SEX M/F	Date of Birth MO/DA/YR	Social Security Number	Primary Care Provider (Optional)	Current Patient Yes/No	RELATIONSHIP: h- husband w- wife s - son d - daughter y- dom part /male x- dom part /female
01 Legal Spouse/Domestic Partner:		/ /	- -			(Circle One) H / W / Y / X
02 Child:		/ /	- -			S / D
03 Child:		/ /	- -			S / D
04 Child:		/ /	- -			S / D
05 Child:		/ /	- -			S / D

Note Please provide address of any Dependent if different from Employee: Dependent Name: _____
Address: _____ City: _____ State: _____ Zip: _____

PART II: DENTAL COVERAGE - AMERITAS Premium Deduction- Pre-Tax Post-Tax
 (Premiums for Domestic Partners are not eligible for Pre-Tax Benefits)

PLEASE NOTE: Dependents can enroll without penalty at this annual enrollment period, even if declined previously.
 I elect Dental Coverage for:
 Employee Only **Note: Since CDS pays the full cost of the Employee Only premium for those employees working 40 hours/week, it is required that these employees be enrolled. Premiums for Domestic Partners must be Post-Tax**
 Employee + 1
 Employee + 2 or more
 I do not want Dental Coverage _____ Initials

EMPLOYEE AND DEPENDENT INFORMATION - DENTAL

List Dependents To be Covered:	SEX M/F	Date of Birth MO/DA/YR	Social Security Number	RELATIONSHIP: h- husband w- wife s - son d - daughter y- dom part /male x- dom part /female
01 Legal Spouse/Domestic Partner:		/ /	- -	(Circle One) H / W / Y / X
02 Child:		/ /	- -	S / D
03 Child:		/ /	- -	S / D
04 Child:		/ /	- -	S / D
05 Child:		/ /	- -	S / D

If an over age 19 dependent is a full-time student please obtain and submit to Health Plans Inc. a letter from the registrar at the school.

Note Please provide address of any Dependent if different from Employee: Dependent Name: _____
Address: _____ City: _____ State: _____ Zip: _____

NOTE: Unum Lifestyle Life policy number is 135739; Unum LTD policy number is 134629

PART III: SUPPLEMENTAL LIFE AND AD&D: Paid for by Employee on a Post Tax basis. (Note: If coverage is not elected within 30 days of becoming eligible, you will be considered a late entrant and future applications will require Proof of Good Health).

Please Check Coverage Amount Below: Increments of \$10,000 to a maximum of the lesser of 5x earnings or \$500,000. *Guaranteed Issue amount for first time eligible enrollees is \$150,000. Any amount over this will require Proof of Good Health form.

- | | | | | |
|--|---------------------------------|---------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> I elect Supplemental Life and AD&D | <input type="checkbox"/> 10,000 | <input type="checkbox"/> 40,000 | <input type="checkbox"/> 70,000 | <input type="checkbox"/> 100,000 |
| | <input type="checkbox"/> 20,000 | <input type="checkbox"/> 50,000 | <input type="checkbox"/> 80,000 | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> 30,000 | <input type="checkbox"/> 60,000 | <input type="checkbox"/> 90,000 | |
| <input type="checkbox"/> I do not want Supplemental Life and AD&D Insurance: ____ Initials | | | | |
| <input type="checkbox"/> I elect Spouse Life Insurance | <input type="checkbox"/> 5,000 | <input type="checkbox"/> 20,000 | <input type="checkbox"/> 35,000 | <input type="checkbox"/> 50,000 |
| | <input type="checkbox"/> 10,000 | <input type="checkbox"/> 25,000 | <input type="checkbox"/> 40,000 | |
| | <input type="checkbox"/> 15,000 | <input type="checkbox"/> 30,000 | <input type="checkbox"/> 45,000 | |
| <input type="checkbox"/> I do not want Spouse Life Insurance ____ Initials | | | | |

Spouse amount cannot exceed 100% of Employee amount; spouse Guarantee Issue is \$50,000

Beneficiary Designation: All employees **MUST** designate a beneficiary. If more than one Beneficiary is named, indicate percentage.

Name of Beneficiary	Relationship	Social Security #	Date of Birth	Address	%
Primary					
Primary					
Secondary					

B) DEPENDENT LIFE INSURANCE - Paid for by Employee on a Post Tax basis (The employee will be the beneficiary)

- | | | | |
|--|--------------------------------|--------------------------------|---|
| <input type="checkbox"/> I elect Child Life Insurance: | <input type="checkbox"/> 2,000 | <input type="checkbox"/> 6,000 | <input type="checkbox"/> 10,000 |
| | <input type="checkbox"/> 4,000 | <input type="checkbox"/> 8,000 | <input type="checkbox"/> I do not want Child Life Insurance ____ Initials |

Note: Dependent Child(ren): 14 days to Age 1 year Benefit is limited to \$500

**PART IV: OPTIONAL LONG TERM DISABILITY - Unum - Paid by Employee on a Post Tax Basis
(Non Taxable Benefit)**

I elect Long Term Disability Insurance

I do not want Long Term Disability Insurance _____ Initials

Note: If coverage is not elected within 30 days of first becoming eligible, you will be considered a late entrant and future applications will require Proof of Good Health

PART V: MEDICAL EXPENSE REIMBURSEMENT ACCOUNT - Administered by HPI Pre-Tax

I elect to participate in Employer sponsored Medical Care Reimbursement Account Program.

I authorize \$_____ per pay period for a maximum of 24 pay periods to be used for Medical Care Reimbursement.

Annual contribution \$ _____

Maximum of \$2,000 annually; Minimum of \$240 annually (to be pro-rated based on date of hire)

I do not want to participate in the Medical Care Reimbursement Account Program _____ Initials

Note: Most over the counter medications are eligible for reimbursement. Please see list of eligible items.

PART VI: DEPENDENT CARE REIMBURSEMENT ACCOUNT - Administered by HPI Pre-Tax

I elect to participate in Employer sponsored Dependent Care Reimbursement Account Program.

I authorize \$_____ per pay period for a maximum of 24 pay periods to be used for Dependent Care Reimbursement.

Annual Contribution \$ _____

Maximum of \$5,000 or \$2,500 if married filing separate returns

I do not want to participate in the Dependent Care Reimbursement Account Program _____ Initials

PART VII: AUTHORIZATION

I hereby request coverage for myself and all dependents as indicated on this form and authorize my employer to make necessary deductions from my earnings unless indicated otherwise. I understand that if I do not enroll when first eligible, I will not be able to obtain coverage in the future except at annual enrollment or within 30 days of a family status change as listed below:

1. Marriage; 2. Divorce or legal separation; 3. Death of a spouse or dependent; 4. Birth or adoption of a child; 5. Termination or commencement of spouse's employment; 6. A change in employment status of the employee or his/her spouse from part-time to full-time, or full-time to part-time; 7. The taking of an unpaid leave of absence by the employee or his/her spouse; 8. A significant change in the health coverage of the employee or his/her spouse's employment.

I certify that all the information furnished by me is true and correct. I understand that if I have provided any false, incomplete, or misleading information, then my coverage under this Plan may result in a denial of all benefits. I understand that all benefits are subject to the terms and conditions stated in the certificates.

Notice: A person commits insurance fraud, if he or she submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

I understand that an employee must be actively at work on the effective date for Life and/or Disability coverage to begin. I also understand that my dependents must not be totally disabled for Dependent Life Coverage to go into effect.

Employee

SIGNATURE _____ **DATE** _____

*****PLEASE DO NOT FORGET TO SIGN AND DATE THIS FORM *****