EMPLOYEE ENROLLMENT FORM

Group Name: _____

EMPLOYER INFORMATION (TO BE COMPLETED BY HR)		
Enrollment (check one): ☐ New Enrollment ☐ Change of Enrollment Status		Effective Date of Insurance/Change:
Enrollment/Change Reason: ☐ New Employee ☐ Rehired Employee ☐ Open Enrollment ☐ Transfer from Other Plan ☐ Involuntary Loss of Other Coverage (Prior Coverage Certificate required) ☐ Marriage ☐ Divorce ☐ Adoption (Legal Documents May be Required) ☐ Dependent Change ☐ Other Qualifying Event: _____ Date of Event:		
Date of Hire:	Date Employee Entered Eligible Class (if not date of hire):	Employee Class:
Employee Hours Worked Per Week:	Job Title:	

EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)		
Employee Name:	Phone:	Email:
Mailing Address:	City: State:	Zip:

Add	Drop	Relationship to Employee	Name (Last, First, MI)	Social Security Number (required)	Date of Birth	Gender	
						Male	Female
☐	☐	Self					
☐	☐	Spouse/Domestic Partner					
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

Is any child over the dependent age limit of 26, applying for coverage due to disability? ❑No ❑Yes If yes, see Human Resources for additional paperwork.

BENEFIT PLAN SELECTION (TO BE COMPLETED BY EMPLOYEE) Please only choose one election each for medical, vision and dental.					
United Healthcare Medical/Rx Plans	**Enrollment Election:**				
	☐ Employee Only	☐ Employee + Spouse/Domestic Partner	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
	Product Selection – Choose one plan only:				
	Flat Copay Plans ☐ Premier 500 ☐ Premier 750 ☐ Premier 1500 ☐ Premier 2500 ☐ Premier 3000	Split Copay Plans ☐ Preferred 750 ☐ Preferred 1250 ☐ Preferred 1500 ☐ Preferred 2000 ☐ Preferred 3000	Consumer Plans ☐ Consumer 1000 ☐ Consumer 2000	HSA Plans ☐ HSA 1750 ☐ HSA 2500 ☐ HSA 3000	
Standard Insurance Company Dental Plans (Complete if offered by employer)	☐ Employee Only	☐ Employee + Spouse/Domestic Partner	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
Standard Insurance Company Vision Plans (Complete if offered by employer)	**Enrollment Election:**				
	☐ Employee Only	☐ Employee + Spouse/Domestic Partner	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline

Life/AD&D Insurance Beneficiary Information:

Beneficiary Name	Relationship	Address	% of Benefit Payable to Beneficiary (must total 100%)

Consumer Driven Health Plan Administration (Please also complete and attached the appropriate BSI enrollment form.)	☐ Flexible Spending Account (FSA)	☐ Health Reimbursement Account (HRA)	☐ Health Savings Account (HSA)	☐ Dependent Care Assistance Plan (DCAP)	☐ Decline

EMPLOYEE SIGNATURE In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. AGC Health Benefit Trust, BSI, and The Insurance Companies may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. The Insurance Companies may also disclose PPI to state and/or federal agencies, or other third parties, as required by law. This authorization, unless revoked earlier, expires 24 months after the date it is signed.

Employee Signature Print Name: Date:

Under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employees, particularly those that waive coverage, may be eligible to late enroll in a medical coverage offered under the AGC Health Benefit Trust (the "Trust"), even if they previously declined coverage. This right extends to the employee and all eligible family members.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline coverage because you have other coverage, you may be eligible to enroll yourself and eligible family members in the Trust if, during the year, you or your family members have a special enrollment event. The following is a list of special enrollment events:

- You or your family member loses coverage in the other plan ended due to termination of employment, divorce/termination of life partnership, death, loss of dependent status or a reduction in hours that affected benefits eligibility;
- You or your family member loses coverage in the other plan ended because you or your dependents no longer live or work in the plan's service area;
- You or your family member loses coverage in the other plan ended because the employer contributions to the plan stopped;
- You or your family member loses coverage in the other plan ended because plan was terminated or discontinued;
- You or your family member's COBRA coverage ended;
- You or your family member ceases being eligible for Medicaid or your state's Children's Health Insurance Program (CHIP) coverage;
- You or your family member become newly eligible for a state premium assistance program for qualifying child to pay for an employer health plan; or
- You acquire a new family member during the year as a result of marriage, birth, adoption or placement for adoption.

Please note that special enrollment rights will be extended only if you notify Benefit Solutions, Inc. at (877) 694-8291 within 30 days of the loss of coverage or acquiring a new family member or within 60 days for ceasing to be eligible Medicaid/CHIP or becoming eligible for State premium assistance.

If you meet any of the above requirements, you will be allowed one of these options:

- Enroll in any medical plan option designated by your employer for which you and your family members are eligible; or
- Enroll your dependents in your current medical coverage.

If you have any questions or concerns please contact Benefit Solutions, Inc. at (877) 694-8291.