# FINANCIAL NETWORK GROUP HEALTH PLAN

## 2021 Annual Enrollment Form

### Employee Information

| Last Name: | First Name: | MI: |
|---|---|---|
| | | |

| Address: | City: | St: | Zip: |
|---|---|---|---|
| | | | |

| Date of Birth: | Social Security Number: | Phone: | Coverage Effective Date: |
|---|---|---|---|
| | | | |

| Email Address: | Annual Salary $ (or prior yr earnings) | ☐ Full-Time ☐ Part-time Hours/Wk |
|---|---|---|
| | | |

| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) | Gender: ☐ Male ☐ Female | Does your spouse work? ☐ Yes ☐ No | Do you have coverage elsewhere (such as your spouse's employer)? ☐ Yes (complete box D) ☐ No |
|---|---|---|---|
| | | | |

### (A) Dental

| ***Choose One*** | Employee Only | Employee & Spouse | Employee & Child(ren) | Employee & Family |
|---|---|---|---|---|
| ☐ Dental Plan- Plan A | ☐ $46.15/mo | ☐ $ 90.63/mo | ☐ $123.39/mo | ☐ $167.83mo |
| ☐ Dental Plan- Plan B | ☐ $62.11/mo | ☐ $121.87/mo | ☐ $164.88/mo | ☐ $224.68/mo |
| ☐ Waive Coverage | | | | |

### (B) Vision

| ***Choose One*** | ☐ Employee Only | ☐ Employee & One | ☐ Employee & Family |
|---|---|---|---|
| ☐ Vision Plan | $8.43/mo | $16.25/mo | $27.77mo |
| ☐ Waive Coverage | | | |

### (C) List All Eligible Family Members Enrolled For Dental, Vision

| Name *(Last, First, MI):* | Gender M F | Birth Date *(Mo./Day/Yr.)* | Social Security #. | Relationship |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

### (D) Information About Other Group Dental Coverage you will continue

| Name *(Last, First, MI):* | Dental | Other Employer | Name and Number of Plan |
|---|---|---|---|
| | ☐ | | |
| | ☐ | | |

### (E) Disability (Salary must equal amount entered on page one) Note: EOI required if increasing coverage

| | | |
|---|---|---|
| ☐ Short Term Disability ☐ Waive | (Enter Salary Amount) $ | • Benefit equals 60% of weekly salary up to a $3,500 benefit.<br>• Rate is $0.29 per $10 of weekly benefit covered. |
| ☐ Long Term Disability ☐ Waive | (Enter Salary Amount) $ | • Benefit equals 60% up to a $15,000 maximum monthly benefit)<br>• Rate is $0.67 per $100 of monthly covered payroll |

**Please remember in addition to your monthly premium there is an annual enrollment fee of $475/participant as well as a monthly participant administration fee reflected on Confirmation Statement**

***IMPORTANT: Complete both pages of this form***

**(F) Life Insurance/Accidental Death & Dismemberment (Salary equals amount entered on page one) If life amount is greater than $300,000 Evidence of Insurability form is required)**

**F1.Basic Life $25,000: List Your Beneficiaries For Life and AD&D Insurance. Monthly Premium: $13.30**

| | |
|---|---|
| Primary *(Last/First/MI):* | Relationship: |
| Contingent *(Last/First/MI):* | Relationship: |

| Age | Mo. Rate/$1,000 | Age | Mo. Rate/$1,000 |
|---|---|---|---|
| 15-24 | .11 | 50-54 | .37 |
| 25-29 | .11 | 55-59 | .58 |
| 30-34 | .13 | 60-64 | .82 |
| 35-39 | .14 | 65-69 | 1.32 |
| 40-44 | .19 | 70-74 | 2.11 |
| 45-49 | .25 | 75+ | 6.42 |

| F2. Employee Life/AD&D) | ☐ 1 X Salary | ☐ 2 X Salary | ☐ 3 X Salary | ☐ WAIVE |
|---|---|---|---|---|

**List Your Beneficiaries For Life and AD&D Insurance for the above elected coverage.**

| | |
|---|---|
| Primary *(Last/First/MI):* | Relationship: |
| Contingent *(Last/First/MI):* | Relationship: |

If more than one primary or contingent beneficiary is to be specified, attach beneficiary information on a separate page. Unless otherwise specified, payment will be shared equally by all primary beneficiaries who survive the Insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise stated. If you are married, but choose someone other than your spouse as beneficiary, have your spouse sign below to acknowledge the other beneficiary.

Spouse's Signature: Date:

| **F3. Spouse Life** EOI on amounts greater than $25,000 (Premium Based on Age Chart above.) | ☐ Enter Amt $_____ (must not exceed EE Election) ***Amount must be in increments of $5,000.*** | ☐WAIVE |
|---|---|---|

| Spouse Name: | Sp DOB: | Sp SSN: |
|---|---|---|

| **F4. Child Life** | ☐ $5,000 ($2.70/mo) | ☐ $10,000 ($5.40/mo.) * | ☐WAIVE |
|---|---|---|---|

**If child life is elected, please provide dependent information in Section D above**

## (G) Mid-Year Change Information

To add or delete dependents or make a plan change midyear, (1) check the qualifying event allowing the change and (2) indicate the date of the event below: Event allowing dependent addition and some plan changes (event must have been within the last 31 days): The change in election must be consistent with the event. ☐Marriage ☐ Birth of child ☐ Court-ordered custody/support/legal guardianship ☐ Adoption/Pre-adoptive placement. (If dependent has or had other coverage within last 63 days, provide Certificate of Creditable Coverage.) ☐Dependent lost eligibility for other coverage due to, specify:

The Date of Event is the last date of the other coverage:

Event allowing/requiring dependent deletion and some plan changes: The change in election must be consistent with the event.
(Notify Amy Ahrens when a covered dependent loses eligibility (within no more than 30 days). Notice for COBRA continuation within 60 days.

☐Death of Dependent ☐Divorce/legal separation ☐Change in support order ☐Other loss of dependent status due to, specify:

The Date of Event is the last date of the other coverage:

## (H) Authorization

I have been given the opportunity to enroll in the Financial Network Group Benefit Plan. I authorize Financial Network Group Benefit Plan to make any necessary deductions from my pay for elected coverages. Medical, and dental and other health and disability deductions will be deducted pre-tax from my pay unless I contact Human Resources to indicate a different election. I understand that I cannot change my benefit enrollment elections until the next open enrollment period unless I have a qualified change in status (which must be reported to Human Resources within 31 days of the event). I authorize payment of medical benefits to preferred providers where applicable, for those charges covered by my group insurance benefits. I authorize release, for the term of my coverage, to or by my physician or health care provider of any medical information including copies of medical records, or insurance carrier with information necessary to establish student eligibility. This authorization will remain valid during my term of coverage under my group insurance plan or 12 months, whichever is less. I or my authorized representative may request a copy of this authorization and a photocopy of this authorization will be considered valid.

Employee Signature (typed name serves as signature) Date

**Forms may be submitted by clicking blue button:** Submit Form

**Please remember in addition to your monthly premium there is an annual enrollment fee of $475/participant as well as a participant administration fee reflected on Confirmation Statement**