2019-2020 (Oct-Oct) Enrollment Form
ASSOCIATES

Effective Date:			**Date of Hire:**	

Purpose - Dates Required

- ❑ Open Enrollment
- ❑ New Hire
- ❑ Re-Hire Date:________
- ❑ Part Time to Full Time
  Date FT: _________
- ❑ Qualifying Event
- ❑ Add Dependent
- ❑ Terminate Dependent
- ❑ Terminate - Other Coverage
- ❑ Reduction of Hours
- ❑ Name Change
- ❑ Address Change
- ❑ Salary Change
- ❑ Plan Change
- ❑ Going on Medicare

Effective Date of QE: ____________________

Reason: ❑marriage ❑divorce ❑birth ❑death
❑court order** ❑adoption** ❑loss/gain of coverage**

**provide supporting documents

Employee Information

Employee Name (Last, First, Middle) ______ *DOB* ______ *SSN* ______

Current Home Address (Street, Apt#) ______ *City* ______ *State* ______ *Zip* ______

Home Phone # ______________________ ❑Male ❑Female ❑Single ❑Married

Email address ______________________ Job Title:_____________________________ Job Class:___________________________

Salary $:___________________ ❑Hourly

Must complete application in **FULL** or it will be returned resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Dependent Information (covered dependents only)

Names of Covered Family Members	Gender		DOB	SSN
Spouse:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		
Child:	❑Male	❑Female		

Medical (per pay period - weekly)

BlueCross BlueShield of Texas (Deductions to be paid out 48 pay-periods (1st-4th wk of month) for equal monthly billing.)

HDHP $6,650 Plan - (Preventative covered 100%-see guide for details)

Up to $12.50 per hour		**$12.51 to $14.50**		**$14.51 to $16.50**	
❑ Employee Only	$39.25	❑ Employee Only	$46.75	❑ Employee Only	$54.25
❑ Employee + Spouse	$194.37	❑ Employee + Spouse	$201.87	❑ Employee + Spouse	$209.37
❑ Employee + Child(ren)	$161.14	❑ Employee + Child(ren)	$168.64	❑ Employee + Child(ren)	$176.14
❑ Employee + Family	$304.11	❑ Employee + Family	$311.61	❑ Employee + Family	$319.11
$16.51 to $18.50		**$18.51 to $20.50**		**$20.51 to $22.50**	
❑ Employee Only	$61.75	❑ Employee Only	$69.25	❑ Employee Only	$76.75
❑ Employee + Spouse	$216.87	❑ Employee + Spouse	$224.37	❑ Employee + Spouse	$231.87
❑ Employee + Child(ren)	$183.64	❑ Employee + Child(ren)	$191.14	❑ Employee + Child(ren)	$198.64
❑ Employee + Family	$326.61	❑ Employee + Family	$334.11	❑ Employee + Family	$341.61
$22.51 to $24.50		**$24.51 to $26.50**		**$26.51 and up**	
❑ Employee Only	$84.25	❑ Employee Only	$91.75	❑ Employee Only	$111.66
❑ Employee + Spouse	$239.37	❑ Employee + Spouse	$246.87	❑ Employee + Spouse	$266.78
❑ Employee + Child(ren)	$206.14	❑ Employee + Child(ren)	$213.64	❑ Employee + Child(ren)	$233.54
❑ Employee + Family	$349.11	❑ Employee + Family	$356.61	❑ Employee + Family	$376.52

❑ Waive

HSA Deductions (per pay period)

HSA Plan Contribution

Please Note: It is your responsibility to ensure you are eligible to contribute and that you do not exceed the maximum contribution allowed

- ❑ Single $ ____________ per pay period *(Annual IRS Contribution limit 2019-$3,500 | 2020-$3,550)*
- ❑ Family $ ____________ per pay period *(Annual IRS Contribution limit 2019-$7,000 | 2020-$7,100)*
- ❑ Over 55 catch up $ ____________ per pay period *(Annual IRS Contribution limit $1,000) - in addition to Single or Family Election*

❑ Waive

Dental (per pay period)

BlueCross BlueShield of Texas (Deductions to be paid out 48 pay-periods (1st-4th wk of month) for equal monthly billing.)

Dental Plan - Low Plan 11		Dental Plan - High Plan 24	
❑ Employee Only	$3.31	❑ Employee Only	$7.51
❑ Employee + Spouse	$6.61	❑ Employee + Spouse	$15.02
❑ Employee + Child(ren)	$10.27	❑ Employee + Child(ren)	$21.05
❑ Employee + Family	$15.18	❑ Employee + Family	$31.66

❑ Waive

Vision (per pay period)

EyeMed Vision (Deductions to be paid out 48 pay-periods (1st-4th wk of month) for equal monthly billing.

Vision Plan	
❑ Employee Only	$1.64
❑ Employee + Spouse	$3.12
❑ Employee + Child(ren)	$3.29
❑ Employee + Family	$4.83

❑ Waive

I verify that the information provided in this enrollment form is accurate and complete. I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan (Section 125), and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or if I experience a significant change in family status (called a "Life Event") such as, gaining or losing dependents through Birth, Death, Marriage, Divorce, or gaining or losing other health coverage, etc. I understand that I must make any changes within 30 days of the approved "Life Event." I understand that by not applying for the coverages contained herein, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for approval. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed. Additionally, I agree, for myself and for any eligible dependent listed, to abide by the rules and regulations of the plan, terms and conditions of all the Service Agreements for the Plans I have elected.

_____________________________ *Employee Signature*

_____________________________ *Date*