Administaff

BENEFITS ENROLLMENT / CHANGE REQUEST

INSTRUCTIONS: Employee completes Parts A, B, C and D of this Enrollment form, reads the terms and conditions on the reverse of the form, signs, dates and forwards the completed original form to his or her Benefits Specialist at Administaff within 30 days of eligibility. **NOTE: It is important to complete this form even if you choose to waive coverage.** If you fail to supply Administaff with a completed Enrollment form within 30 days of eligibility, coverage will be waived automatically.

FOR INTERNAL USE ONLY	Employer Name **Administaff**	Vendor Name	Client No.	Client Wait Period	Effective Date
	Signature – Benefits Administration Representative		Signature Date		Full-Time Employment or Return-to-Work Date

A. Enrollment / Change Designation (Check the applicable event box below and complete the requested information.)

❑ **ENROLLMENT**
Check Reason:
- ❑ New Enrollee
- ❑ Rehire or Reinstatement of Coverage or Re-enrollment

❑ **CHANGE**
Check Reason:
- ❑ Primary Care Provider
- ❑ Add Dependent
- ❑ Remove Dependent
- ❑ Other _____

Qualifying Event (check ONE):
- ❑ ANNUAL OPEN ENROLLMENT
- ❑ Change in Status (Specify): _____

Date of Qualifying Event

❑ **TERMINATION**
Check Reason:
- ❑ Terminating Employment
- ❑ Layoff/Leave of Absence
- ❑ Cancelling Coverage
- ❑ Death

B. Employee Information (Complete ALL fields.)

Employee Last Name	Employee First Name	Employee Middle Name or Initial	Marital Status ❑Married ❑Single ❑Other
Employee Street Address	**City**	**State**	**Zip Code**

Employee Social Security No.	Sex ❑M ❑F	Home Telephone No. ( )	Work Telephone No. ( )	Date of Birth	Occupation

Life Insurance Beneficiary Designation — You may designate one or more beneficiaries. If you designate more than one, indicate the percentage of benefit assigned to each.
(NOTE: Use given names, not initials. Example: Mary R. Smith, ***not*** M. R. Smith or Mrs. John Smith.)

Beneficiary Name (First Name, Middle Initial, Last Name)	Relationship to Employee	Address of Beneficiary (include Street Address, City, State & Zip Code)	Percent of Benefit
			%
			%

C. Health Care Coverage Options

NOTE: If health care coverage is being WAIVED, employee MUST complete and sign Waiver of Insurance on back of this form.

SELECT ONLY ONE OPTION

❑ **PPO Option — Preferred Provider Organization** If your home zip code falls outside a network area, you will be enrolled in the Out-of-Area Plan. However, it may be possible to participate within a managed care program. For further information, contact your Administaff Benefits Specialist.

❑ **HMO / EPO / EPP Option* — where available** (Health Maintenance Organization; Exclusive Provider Organization; Exclusive Provider Program)
HMO/EPO/EPP programs do not provide coverage for services received outside the network associated with a covered employee's zip code service area. (Exceptions may be approved by the insurance provider for certain emergency or legally mandated situations.)
Massachusetts ONLY: You may elect one of the following insurance carriers *where available in the zip code in which you reside or work:*
☐ **UnitedHealthcare (HMO / EPO)** OR ☐ **CIGNA EPP** OR ☐ **Tufts Health Plan HMO**
California ONLY: You may elect one of the following insurance carriers *where available in the zip code in which you reside or work:*
☐ **BlueShield of California (Northern CA only)** OR ☐ **PacifiCare** OR ☐ **Kaiser Permanente –** *Requires completion of the Kaiser Foundation Health Plan Arbitration Agreement on the back of this form.*

❑ **Dental-Only Option — NOTE: Not all plans offer a Dental-Only option.**
Please consult your on-site supervisor or your Administaff Benefits Specialist to determine if you are eligible for the Dental-Only option. If you check the box to select the Dental-Only option, you are waiving enrollment for health care coverage (and may be waiving other coverage options, such as life and disability) under the Administaff benefit plan.

D. Dependents To Be Covered

❑ **I elect coverage for my eligible dependents.**
Provide personal information below for EMPLOYEE and ALL DEPENDENTS to be covered. Attach another form if more dependent spaces are needed.

❑ **I do not have eligible dependents / I refuse coverage for my dependents.**
Provide personal information below for EMPLOYEE only.

	Name (First, Middle Initial, Last)	Social Security No. (if none, leave blank)	[A]dd or [R]emove	Rel. Code*	Date of Birth (required)
EMPLOYEE					
Dependent					
Dependent					
Dependent					

Employee completes if HMO/EPP/EPO option is selected (not required for PPO or Dental-Only selection)

Primary Care Provider	OB/GYN Provider
When required by your plan, select a Primary Care Provider (PCP) for yourself and each dependent listed. Refer to the Directory of Providers for provider names and ID numbers.	*Contact your Benefits Specialist to see if your plan permits female members to select an OB/ GYN provider in addition to a PCP. If yes, refer to the Directory of Providers to select.*
Name / ID No.	Name / ID No.
Name / ID No.	Name / ID No.
Name / ID No.	Name / ID No.
Name / ID No.	Name / ID No.

* *Use the following Relationship Codes: H = Husband; W = Wife; M = Dependent Male; F = Dependent Female; P = Domestic Partner*

IF ANY DEPENDENT IS 19 YEARS OF AGE OR OLDER and is a full-time student, or handicapped and financially dependent, complete the following information.
Attach documented proof from educational institution (for students) or physician (if handicapped) for dependent child(ren) between the ages of 19 and 24.
NOTE: Student status is NOT required for the UnitedHealthcare PPO or Texas HMO programs.

Name	Handicapped?	Full-Time Student?	Educational Institution	Date of Graduation (mm/yy)
	❑Yes ❑ No	❑Yes ❑ No		
	❑Yes ❑ No	❑Yes ❑ No		

SIGN & DATE THE FORM

By signing, I acknowledge that I have read all sections on the reverse of this form and agree to all terms and conditions.

Employee Signature	Date

Mail the original of your completed Enrollment / Change Request to your Administaff Benefits Specialist. Keep a photocopy for your records.

Acknowledgments

I understand that misstatements, material misrepresentations or omissions may result in my coverage being void as of its effective date with no benefits payable. I hereby request the group coverage for which I am eligible and authorize all applicable deductions from my earnings (which may change from time to time) to serve as payment for any required contributions. By selecting the medical plan option I've indicated in Section C, I authorize any physicians, other health professionals, hospitals and/or other health care institutions that I consult, as well as any physicians, independent claim administrators, consulting health professionals, and/or utilization review organizations with whom the insurance provider has contracted, to provide to the company administering the coverage information concerning health care advice, treatment or supplies provided to me and/or my dependents (including those involving mental illness) relating to coverage under this plan option. This information will be used for coordinating patient care, evaluating and administering claims for benefits, and for fulfilling obligations imposed on the insurance provider by federal or state law. Under certain arrangements, the insurance provider may provide the employer named above with any benefit calculation used in the payment of these claims for the purpose of reviewing the experience and operation of the policy or contract. My signature on the front of this form affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

I understand that coverage under the medical plan option I've indicated in Section C will be governed by my or my dependents' remaining in an eligible class (as defined by the plan's Summary Plan Description) at the time services are rendered.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact your Administaff Benefits Specialist before signing this form.

Election of Health Care Coverage and Compensation Reduction Agreement

The Administaff Cafeteria Plan falls under Section 125 of the Internal Revenue Code. You may change your decision to elect or reject participation in the Administaff Cafeteria Plan each year ***only*** during the designated annual Open Enrollment period, or within 30 days of a change in your status. A change in status, for this purpose, includes the occurrence of one or more of the following events: marriage, divorce, death of a spouse or child, birth or adoption of a child, employment or termination of employment of a spouse, and such other events that the Plan Administrator determines will permit a change or revocation of an election during the Plan year under regulations and rulings of the Internal Revenue Service.

Each employee is eligible to apply for coverage for themselves and their eligible dependents during an annual Open Enrollment period. Each new employee who becomes eligible shall be entitled to apply for coverage for themselves and their eligible dependents within 30 days after becoming eligible. If an employee does not apply for coverage for himself and all eligible dependents within 30 days after becoming eligible, the next time coverage can be applied for is during the annual Open Enrollment period, unless otherwise required by law. After 30 days, coverage will not be extended to any employee requesting late entry (unless required by law). Coverage for late entry of a dependent may be elected only during the annual Open Enrollment period, except for a "change in status" permitted by the Administaff Cafeteria Plan.

Administaff may change or cancel the amount of your pay reduction or otherwise modify this agreement in accordance with the Administaff Cafeteria Plan if it believes, in its sole discretion, that modification is reasonable and necessary in order to satisfy the provisions of the Internal Revenue Code, or preserve favorable tax treatment for the Administaff Cafeteria Plan participants.

The reduction in your cash compensation under this agreement will be in addition to any reductions under other agreements or benefits plans. This election will not be discontinued until you timely notify Administaff in writing that you would like to change your election due to a qualifying change in status, as defined above, or each year during the designated annual Open Enrollment period.

I elect to participate in the Administaff Cafeteria Plan and authorize Administaff to reduce my gross wages or salary by an amount equal to my contribution for coverage, if any, that I have selected under the Administaff Cafeteria Plan. I understand that the amount of the reduction and the designated amount are subject to change, and that an Enrollment Form must be completed and submitted to Administaff before coverage can be offered.

Pre-Existing Conditions

A pre-existing condition limitation may apply to employees and dependents who elect medical coverage.

A **pre-existing condition** generally means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within a specified **look-back period** (as defined by your elected medical plan) before your coverage eligibility date, or if applicable, before the first day of your waiting period. If a pre-existing condition limitation applies in your situation, no coverage is provided for treatment expenses related to a pre-existing condition for a 12-month **limitation period** unless your medical plan provides for a shorter period (see the Medical Benefits At A Glance chart in the Health/Related Benefits booklet of your Employee Benefits Information Kit, or find the Medical Outline of Benefits link online in the Employee Service Center).

An employee or dependent's pre-existing condition limitation period may be eliminated or shortened one day for each day that the employee or dependent had creditable coverage under another health plan, provided there was not a 63-day lapse in coverage. (A waiting period for plan eligibility is not counted as time associated with a lapse of coverage.)

The pre-existing condition limitation will not apply to:

- Genetic information, unless a condition related to that information is diagnosed.
- Pregnancy or a condition of a newborn or adopted child who became covered within 30 days of birth or adoption (or placement for adoption).
- Eligible employees and their eligible dependents enrolled in a managed care program (HMO/EPO/EPP).

Kaiser Foundation Health Plan Arbitration Agreement

NOTE: If you elect coverage in the Kaiser Permanente HMO plan, you must read, sign and date this Arbitration Agreement.

I understand that, except for small claims court cases, claims subject to a Medicare appeals procedure, and if your group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs, or other associated parties on the one hand and health plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in health plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration.

Employee/Subscriber Signature	Date Signed

Waiver of Insurance

NOTE: Complete this Waiver of Insurance **ONLY** if you are a NEW Administaff employee and DO NOT wish to enroll in the health care coverage option of the Administaff benefit plan at this time, **OR** you are electing the Dental-Only coverage option, if available.

If you wish to cancel your existing enrollment, please check the appropriate box under TERMINATION in Section A on the front of this form.

I have been given the opportunity to enroll in the health care coverage option of the Administaff benefit plan and **I elect not to enroll at this time**. I understand that if I elect not to participate in the health care option by signing this Waiver of Insurance, I may be waiving enrollment for additional coverage options. I understand that if I am declining enrollment for myself and/or my dependents (including spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents, provided that I request enrollment within 30 days after such other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself and/or my dependents provided that I have requested enrollment within 30 days after marriage, birth, adoption or placement for adoption.

Please read the Election of Health Care Coverage and Compensation Reduction Agreement Section of this form before you sign this waiver.

Employee Name:_____ Social Security No._____

Reason for Declining Coverage: ❑ Other Coverage ❑ Other (Explain) _____

Employee Signature	Date Signed

Full details are contained in the plan documents and insurance contracts that govern each benefit. Certificates of Coverage and plan documents are available upon request. Should there be a discrepancy or conflict between the information presented here and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern. Administaff reserves the right to amend or discontinue any plan at any time at its sole discretion. In no event should the benefits provided by Administaff be interpreted as a guarantee of continued employment.