Employee Master Election Form

For Office Use only:

COBRA
Event date_____
EVENT:_____ Termination [Voluntary Involuntary]

_____ Death
_____ Divorce/Legal Separation
_____ Medicare
_____ Dependent ceasing to be a dependent
_____ Employees Reduction of Hours
_____ Layoff
_____ Military Leave of Absence
_____Open Enrollment

Date Submitted ____/____/_____ Submitted By: _____

Healthcare Plus Home Health_____ **Hope Hospice_____**

Job Title: _____ Classification: Full Time_____ Variable_____

_____New Hire
_____Active Employee Change
_____Dependent Change (Add / Drop)
_____**Open Enrollment (PLAN CHANGES)**
_____**Open Enrollment (NO PLAN CHANGES)**
_____Terminated Employee

Hire Date____/____/_____ Termination Date____/____/_____

Effective Date____/____/_____ Termination Effective Date____/____/_____

Employee_____

Address_____

City_____State_____Zip_____

Phone Number_____(Cell/Home/Work) Email: _____

SSN_____ Birth Date____/____/_____ Gender_____

For Dependent Additions & Change:

Spouse's Name_____ SSN_____ Birth Date____/____/_____

Child's Name_____ SSN_____ Birth Date____/____/_____

Child's Name_____ SSN_____ Birth Date____/____/_____

Child's Name_____ SSN_____ Birth Date____/____/_____

PLEASE MAKE SURE TO COMPLETE THE SECOND PAGE OF THIS FORM

Please indicate your benefit elections in the boxes next to the pay period deduction, sign and date:

If you wish to *Waive* all benefit elections please check this box ☐

Date ____/____/_____ **Employee's Signature _____**

	Deductions Bi-Weekly									
	HCP FINANCIAL Blue Cross Blue Shield Rates Effective May 1, 2016									
		HMO Medical		PPO HDHP/HSA		PPO Traditional		PPO BlueChoice Traditional		PPO BlueChoice HDHP -Bronze
Employee only	☐	$163.50	☐	$184.87	☐	$192.21	☐	$107.68	☐	$57.00
Employee+Spouse	☐	$356.76	☐	$403.37	☐	$419.37	☐	$234.95	☐	$324.44
Employee+Children	☐	$300.42	☐	$339.68	☐	$353.15	☐	$197.85	☐	$246.48
Employee+Family	☐	$493.67	☐	$558.17	☐	$580.32	☐	$325.12	☐	$513.93
WAIVE COVERAGE	☐									
	Ancillary Rates Rates Effective May 1, 2016									
		Delta HMO Dental		Delta PPO Dental		EyeMed Vision				
Employee only	☐	$3.92	☐	$8.03	☐	$1.97				
Employee+Spouse	☐	$7.24	☐	$16.07	☐	$3.74				
Employee+Children	☐	$8.18	☐	$18.11	☐	$3.93				
Employee+Family	☐	$11.51	☐	$27.37	☐	$5.78				
WAIVE COVERAGE	☐				☐					

If you elected the Medical HMO Benefit please provide the following information
Medical Group Name:
Medical Group Number:
Primary Care Name:
Primary Care Provider ID:
If you elected the Dental DHMO Benefit please provide the following information
Dentist Name:
Dental ID #: