

# Perry-Hocking Educational Service Center

## Employee Benefit Election Form 2011-2012

Enroll                       Cancel/Terminate                       Change

**Full Name** \_\_\_\_\_ **Social Security #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Gender**  M  F **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**City** \_\_\_\_\_ **ST** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Marital Status**     Single             Married  
**Home Phone** \_\_\_\_\_ **Date Married** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date of Full Time Employment** \_\_\_\_/\_\_\_\_/\_\_\_\_

Make your selection by placing a "✓" in the appropriate coverage boxes and complete the "**Dependent Information**" if applicable.

**Medical**     Employee Only     Employee & Spouse     Employee & Child(ren)     Family     Waive Coverage

**Dental & Vision**     Employee Only     Employee & Spouse     Employee & Child(ren)     Family     Waive Coverage

**Dependent Information**

<input type="checkbox"/> <b>Med</b> _____	<input type="checkbox"/> M	<u>  </u> / <u>  </u> / <u>  </u>	
<input type="checkbox"/> <b>Dent/Vis</b> Spouse's Full Name _____	<input type="checkbox"/> F	Date of Birth	Social Security No. _____
<input type="checkbox"/> <b>Med</b> _____	<input type="checkbox"/> M	<u>  </u> / <u>  </u> / <u>  </u>	
<input type="checkbox"/> <b>Dent/Vis</b> Child's Full Name _____ Student <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> F	Date of Birth	Social Security No. _____
<input type="checkbox"/> <b>Med</b> _____	<input type="checkbox"/> M	<u>  </u> / <u>  </u> / <u>  </u>	
<input type="checkbox"/> <b>Dent/Vis</b> Child's Full Name _____ Student <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> F	Date of Birth	Social Security No. _____
<input type="checkbox"/> <b>Med</b> _____	<input type="checkbox"/> M	<u>  </u> / <u>  </u> / <u>  </u>	
<input type="checkbox"/> <b>Dent/Vis</b> Child's Full Name _____ Student <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> F	Date of Birth	Social Security No. _____

### Authorization of Deductions under "Section 125"

I authorize my employer to redirect "pre-tax" funds from my salary each month as payment towards my eligible Medical Group Insurance Premiums. I understand that I will receive written notification of any increases in the amounts deducted. I understand I have thirty (30) days after receiving such notification to reelect my insurance options and that I must sign this authorization prior to the effective date of my initial redirection. I understand that I cannot change my decision until the beginning of each plan year. The exception to this is a change in family status (qualifying event), such as: marriage, divorce, birth, adoption, death or a change in your spouse's employment. Please refer to your Summary Plan Description for details. Should you desire to deduct your costs on an "after tax" basis, please contact the HR Department for a Section 125 waiver.

**Basic and Voluntary Life Insurance**

Perry Hocking ESC provides a 100% company-paid Basic Life Insurance and AD&D for all full-time employees who have completed their eligibility period. Employees are enrolled to receive \$20,000 Basic Life Insurance Coverage and are required to complete the Beneficiary Designation information below (attach additional sheet if necessary).

- VL - Voluntary Life/AD&D** \$ \_\_\_\_\_ (Min. \$20,000. Increments of \$1,000 up to 5 times your salary or max of 500,000\*)
- VS - Voluntary Spouse Life Insurance** \$ \_\_\_\_\_ (Spouse: \$5,000 increments up to max of \$100,000)
- VC - Voluntary Child(ren) Life Insurance** \$ \_\_\_\_\_ Dependent Child(ren): \$10,000 (review document for age limits)
- Waive Coverage**

**I understand that by not electing the Voluntary Life Insurance listed above, I am waiving the Guarantee Issue of \$100,000. If I choose to elect this coverage in the future, I must provide Evidence of Insurability.**

\*NOTE: Employee must complete an "Evidence of Insurability" form when electing Voluntary Life Volumes greater than \$100,000 and/or \$20,000 for Spouse.

**Beneficiary Designation** (if none specified, death benefits will be paid according to state statutes and contract language)

Designate the policy of insurance to be distributed to the beneficiary, i.e. B = Basic, VL = Voluntary Life; VS = Voluntary Spouse, VC= Voluntary Child(ren). Select whether the beneficiary is the Primary (receives benefits first) or Contingent (receives benefits if something happens to the Primary).

B	VL	VS	VC	First Name & MI	Last	SS#	Relationship	% of Benefit	Primary/Contingent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>

If percentages don't total 100%, death benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, death benefits will be distributed equally. I understand if I decline any of the above coverage's, enrollment of the coverage at a later date will require

- I hereby apply for all insurances as indicated above and on any attached applications, for which I am eligible or may become eligible.
- I authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.
- If contributions are required, I authorize my employer to deduct premiums from my pay. If my pay rate or elections change during the year, I authorize my employer to change the deducted premiums.
- The information provided above is true and correct to the best of my knowledge.
- Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

X \_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed