Enrollment/Waiver Form

Plan Year: **1-01-20 thru 12-31-20**

For Office Use Only:	Effective Date:	Date of First Deduction:	Processed By:	Date:	Annual Earnings:

Employee Name: _____ ___Male ___Female **DOB:** ____/____/____ **SSN**_____

Street Address: _____ **City**_____ **State**_____

Zip Code_____ **County:** _____ **Home Phone:** (_____)_____

Email: _____ **Date of Full-Time Employment** _____/_____/_____ **Occupation:** _____

Marital Status: ___ Single ___Married ___ Widowed ___Divorced ___Legally Separated **Number of Hours worked per week:** _____

Insurance Premiums

I have elected the appropriate coverage(s) listed below and agree to the following insurance premium deduction per pay period through:

☐ **Post-Tax reduction of your salary (allows changes during the year)** ☐ **Pre-Tax reduction of your salary ***

**** If you select Pre-Tax, you cannot make election changes until next December***

CHOOSE YOUR MEDICAL COVERAGES - Each plan can be elected stand alone or you may elect multiple plans depending on your needs – electing the MEC plan avoids the individual mandate penalty.

Kemper Benefits, Group# KB20527 / Anthem BCBS Group #235076

	☐ MEC	☐ Limited Medical	☐ Drug Plan	☐ Anthem $5000 deductible *(only available to those working 30+ hours/week)*
☐ Single	$8.68	$9.27	$7.08	9.5% of your weekly pay not to exceed $73.14/week
☐ Employee + Spouse	$11.68	$15.51	$13.63	Above single cost plus $116.83/week
☐ Employee + Child	$10.52	$14.80	$12.04	Above cost plus $67.10/week
☐ Employee + Child(ren)	$10.52	$14.80	$12.04	Above single cost plus $67.10/week
☐ Family	$13.98	$21.23	$19.30	Above single cost plus $203.53/week

☐ **I waive this coverage** ☐ **I waive medical coverage for my dependents only**

If you are waiving coverage, are you covered under another medical plan? ____ Yes ____ No
If you are waiving dependent coverage, are your dependents covered under another medical plan? ____ Yes ____ No

CHOOSE YOUR DENTAL COVERAGE (Check Plan type and one coverage box only)	**Kemper Benefits. Group# KB20527**
☐ Single	$3.20
☐ Employee + Spouse	$6.40
☐ Employee + Child(ren)	$7.01
☐ Family	$10.21
☐ I waive this coverage ☐ I waive dental coverage for my dependents only	

CHOOSE YOUR VISION COVERGE (Check one coverage box only)	**Kemper Benefits. Group# KB20527**
☐ Single	$1.53
☐ Employee + Spouse	$2.90
☐ Employee + Child(ren)	$3.16
☐ Family	$4.06
☐ I waive this coverage ☐ I waive vision coverage for my dependents only	

CHOOSE YOUR SHORT TERM DISABILITY COVERAGE (Check one coverage box only)		Kemper Benefits. Group# KB20527
Weekly Benefit: 60% of salary to a maximum of $150	☐ Age 18 - 49	$4.40
7 day waiting period / 26 week benefit duration	☐ Age 50 - 59	$4.98
	☐ Age 60 - 64	$5.91
		☐ I waive this benefit

CHOOSE YOUR ACCIDENT EXPENSE COVERGE (Check one coverage box only)		Kemper Benefits. Group# KB20527
	$1,000 benefit	$5,000 Benefit
Single	☐ $1.86	☐ $4.97
Employee + Spouse	☐ $3.71	☐ $10.06
Employee + Child(ren)	☐ $4.51	☐ $12.70
Family	☐ $6.52	☐ $18.57
		☐ I waive this coverage

Please complete if you are enrolling your spouse and/or children in any plan:

Dependents to be insured: (last name if different)	Relationship Spouse/Child	M/F	Social Security #	DOB	Add (A), Change (C), Deletion (D)	Medical	Dental	Vision	Accident

With regards to my salary redirections agreement and my election of benefits, I understand that:

If I elected a pre-tax deduction, I may not change elections during the plan year unless there is a change in my family status (i.e. marriage, divorce, death of my spouse or child, adoptions or birth of my child, change in job status of myself/spouse/dependent (full/part time, termination/beginning of employment), my dependents no longer eligible for insurance coverage, or a legal separation/annulment). I UNDERSTAND THAT I HAVE 30 DAYS FROM THE DATE OF ONE OF THE ABOVE OCCURRENCES TO MAKE A CHANGE IN MY PLAN. I understand that these elections do not constitute guaranteed coverage for any of the insurance listed nor does the cafeteria plan dates listed have any correlations to the effective date of insurance coverage. The administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for the benefits that are insured.

Other Health Coverage / Medicare Please check one: ____ YES ____ NO			
On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage /Medicare.			
Provide name, phone number and address of the HMO or insurance company		Policy/Certificate Number	Effective Date _____/_____/_____
Policy/Certificate holder's name	Social Security Number - -	Date of Birth _____/_____/_____	Relationship to Applicant

Printed Name: _____

Applicant Signature: _____ **Date:** _____/_____/_____