TMC
2010 BENEFIT ENROLLMENT / CHANGE FORM
19 Pay Periods

Employee Number ____________

Region # ____________ Center ____________

Regular F/T ☐

Seasonal F/T ☐ 3 mos ☐ 6 mos ☐

ENROLLMENT

- ☐ Open Enrollment
- ☐ New Employee
- ☐ Rehired / Reinstatement

CHANGE

- ☐ Add / Remove Dependent
- ☐ Address Change ☐ Name Change
- ☐ Beneficiary Change ☐ Transfer / Relocation
- ☐ ***Family Status Change**

***FAMILY STATUS CHANGE – DATE OF EVENT:** ________

Provide supporting documentation and attach to this form

- ☐ Marriage ☐ Birth ☐ Adoption ☐ Death
- ☐ Termination / Reduction in Hours
- ☐ Spouse Loss of Coverage ☐ Legal Separation / Divorce

TERMINATION DATE: ____________

- ☐ Termination of Employment
- ☐ Lay-off / Leave of Absence
- ☐ Death
- ☐ COBRA Continuation

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE NAME: ____________________ SOCIAL SECURITY NO.: ____________ GENDER: ☐ FEMALE ☐ MALE

ADDRESS: ____________________ CITY/STATE/ZIP: ____________________ TELEPHONE: ____________

LOCATION: ____________ DATE OF BIRTH: ____________ DATE OF HIRE: ____________ SALARY: ____________ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED

PRE-TAX BENEFIT PLANS – MEDICAL, DENTAL & VISION PLANS

MEDICAL INSURANCE UNITEDHEALTHCARE

Basic Plan 9TB

Please pick one Medical Plan Option and choose your level of coverage or Decline

Basic Plan 9TB		
EE Only	$ 41.00	☐
EE+ Spouse	$ 88.95	☐
EE + Child(ren)	$ 75.25	☐
EE + Family	$ 116.30	☐

Buy Up Plan 6TX

Buy Up Plan 6TX		
EE Only	$ 61.60	☐
EE+ Spouse	$ 123.15	☐
EE + Child(ren)	$ 109.50	☐
EE + Family	$ 171.00	☐

☐ I Decline Medical Coverage due to Lay-Off Status

☐ I Decline Medical Coverage – other reason

Reason: ☐ Other Coverage

☐ Too Expensive

If coverage is elected for spouse, please indicate:

Wife ☐ Husband ☐ Domestic Partner ☐ Common Law ☐

DENTAL INSURANCE Guardian

		NAP Plan	Value Plan
EE Only	$ 0.00	☐	☐
EE+ Spouse	$ 12.94	☐	☐
EE + Child(ren)	$ 21.11	☐	☐
EE + Family	$ 39.52	☐	☐

☐ I Decline Dental Coverage

Vision Insurance Guardian

EE Only	$ 3.04	☐
EE+ 1 Dependent	$ 5.32	☐
EE + Family	$ 7.91	☐

☐ I Decline Vision Coverage

Basic Life and Long Term Disability – Guardian Life Insurance Company
Provided by TMC to all eligible employees actively working
At no cost to Employees

OTHER COVERAGE INFORMATION: **Will you or your dependents, which you are enrolling in the plan, have any other medical or dental insurance in addition to this plan?** ☐ **Yes** ☐ **No**
If YES, Please indicate carrier information.

Carrier Name	Policy #	Group #	Effective Date:	**Are you enrolled in Medicare?** ☐ **Yes** ☐ **No** **Medicare#** ____________ ☐ **Part A** ☐ **Part B**

ELIGIBLE DEPENDENTS FOR MEDICAL, DENTAL AND VISION PLANS *(Complete only if dependent coverage is elected.)*

Medical, Dental and Vision Plans: Dependent (unmarried) children are covered to age 25.
PREVIOUS COVERAGE NFORMATION: In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependent listed. If you have a certificate of prior coverage, please attach a copy to this enrollment form. (If more than one plan was in effect or if information is different for dependents, attach additional pages.) If Medicare, Please submit copy of your card.

Dependent Names (Full Name)	Social Security No.	Gender (Circle One)	Date of Birth	Relationship	Medical Add/Cancel	Dental Add/Cancel	Vision Add/Cancel
Spouse		M / F			☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL
Child-1		M / F			☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL
Child-2		M / F			☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL
Child-3		M / F			☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL
Child-4		M / F			☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL
Child-5		M / F			☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL	☐ ADD ☐ CANCEL

HIPAA: If you are declining enrollment for yourself or your dependents because of the other group health coverage, you may in the future be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

AUTHORIZATIONS:

PRE-TAX ELECTION

☐ YES – I authorize my employer to reduce my taxable salary in accordance with my election in any of the above referenced benefits under the TMC Premium Only Plan.

POST-TAX ELECTION

☐ NO – I do not authorize my employer to reduce my taxable salary in accordance with my election in any of the above referenced benefits under the TMC Premium Only Plan.

SENATE BILL 51 – Requires that your insurance coverage continue until the last day of the month in which you terminate employment. You are responsible for the insurance premiums for the entire month.

☐ If my employment should end at TMC, I understand that TMC , will deduct any remaining premiums for the month in which I terminate from my final paycheck.

By participating in the TMC Premium Only Employee Benefit Plan ("Plan"), I agree to be bound by all the terms, conditions and limitations of the Plan and any and all separate plans, contracts and documents made a part thereof. I agree to have my gross salary reduced by the amount of the cost of benefits selected and understand that this amount will not be subject to Social Security or federal income tax withholding, which may result in a reduction of future Social Security benefits to which I may be entitled. My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge. I understand that any misrepresentation of a material fact on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable.

______________________________ Employee Acknowledgement (Signature Required)

______________________________ Date