SHULMAN ROGERS

2021 PLAN YEAR OPEN SEASON EMPLOYEE ELECTION CHANGES

☐ NEW SUBSCRIBER ☐ MEMBER Adding New Line of Coverage ☐ WAIVER (Signature Required) ☐ COBRA

Employee's Last Name First Middle Title (Jr., III, etc.)	Social Security #	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Employee's Address Number Street Address Name Apt #		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
City State Zip Code		Home Phone # (include area code) Cell Phone # (include area code)	
Employee's E-mail Address:	Employee's Occupation:		
Date of Hire (Mo./Day/Yr.)	☐ Full-Time ☐ Part-Time		Coverage Effective Date ________________ On Effective Date, Actively At Work ☐ Yes ☐ No

Last, Full First, Middle Initial	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)	Disabled (Y/N)
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Are you or any of your dependents eligible for Medicare? ☐ Yes ☐ No If Yes, Effective date Part A ____/_____/_____ Effective date Part B ____/_____/_____

CIGNA HEALTH PLANS		CIGNA DENTAL PLAN		UNITEDHEALTHCARE VISION PLAN		Flexible Spending Accounts ☐ Medical **($2,750 Annual Max.)** ☐ Dependent **($5,000 Annual Max.)**
Please Select:	Select Level of Coverage:	Please Select:	Select Level of Coverage:	Please Select:	Select Level of Coverage:	Annual Election**
☐ HMO	☐ Employee Only	☐ CIGNA DPPO	☐ Employee Only	☐ UHC	☐ Employee Only	☐ Medical $_______________
☐ POS	☐ Employee & Child(ren)	☐ WAIVE	☐ Employee & Child(ren)	☐ WAIVE	☐ Employee & Child(ren)	☐ Dependent $ _____________
☐ HSA POS	☐ Employee & Spouse		☐ Employee & Spouse		☐ Employee & Spouse	☐ **Limited Purpose*** $________
☐ WAIVE	☐ Family		☐ Family		☐ Family	☐ WAIVE
						Plan Year: 1/1/21 – 12/31/21
						***For HSA Participants Only** ☐ HSA Bank Account* $________

Other Insurance Information

Will you or your dependents continue health coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name ________________________

Policy # ________________________

Who Is Covered? ☐ Self ☐ Spouse ☐ All

Effective Date ______/_____/______ Term Date_____/_____/______

CERTIFICATION

I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become a part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form, to the best of my knowledge and belief, are full, complete and true as of this date. I further certify that I am the spouse, parent, or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact Human Resources before signing this Election Form.

THIS IS NOT AN APPLICATION FOR INSURANCE

EMPLOYEE SIGNATURE ______________________________ Date ____/_____/_____

EMPLOYER SIGNATURE/ VERIFICATION ______________________________ Date ____/_____/_____