ISLAND FOUNDATION
DEDICATED TO EXCELLENCE AT SEASHORE CHARTER SCHOOLS

Monthly 2023-2024 ENROLLMENT/CHANGE FORM

EMPLOYEE INFORMATION

DATE OF HIRE:_____

Last Name:	**First Name:**	**Home Phone Number:**	**Gender:** ☐ Male ☐ Female
Birth Date (MM/DD/YYYY):	**Social Security Number:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Street Address:	**City:**	**State:**	**Zip:**

MEDICAL ELECTION

☐ **ENROLL** ☐ **DECLINE COVERAGE ***

Make your selection for each option, even if declining coverage, by checking the appropriate box. Rates are based on bi-weekly pay cycles, the amounts shown is the amount that will be deducted from your pay check EACH pay period.

Humana – Simp Opt 14

Deductible: $0/$5000 Coinsurance: 100/50
ER/UC: $600/$125 Office Visit: $40/$100
Hospital: $2000 a day/First 3 days
Rx: Walmart/CVS/HEB, $10/$45/$90/25%

Medical Pay Period Deductions

☐ $169.10 Employee Only
☐ $642.03 Emp + Spouse
☐ $523.79 Emp + Child(ren)
☐ $1036.12 Emp + Family

DEPENDENT INFORMATION

Relationship	Last Name	First Name		Social Security Number	Date of Birth (MM/DD/YYYY)
SPOUSE ☐ Male ☐ Female					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					

Please use a separate sheet to list additional dependents if necessary.

OTHER MEDICAL COVERAGE

***If you are declining coverage for yourself or a dependent, will you, your spouse, or any of your dependents be covered under any other medical plan or policy including another Humana plan, Medicaid or Medicare? ☐ Yes ☐ No**

DENTAL ELECTION

☐ **ENROLL** ☐ **CANCEL COVERAGE** ☐ **ADD DEPENDENT** ☐ **DECLINE COVERAGE***

Make your selection for each option, even if declining coverage, by checking the appropriate box.

☐ $32.77 Employee Only
☐ $65.53 Employee + Spouse
☐ $83.55 Employee + Child(ren)
☐ $116.32 Employee + Family

VISION ELECTION

☐ **ENROLL** ☐ **CANCEL COVERAGE** ☐ **ADD DEPENDENT** ☐ **DECLINE COVERAGE***

Make your selection for each option, even if declining coverage, by checking the appropriate box.

☐ $11.03 Employee Only
☐ $22.06 Employee + Spouse
☐ $20.95 Employee + Child(ren)
☐ $32.93 Employee + Family

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I understand that if I waive any benefits at initial eligibility for myself and/or my dependents (including my spouse) I will be unable to enroll until the next open enrollment period which begins in August. However, if I waive benefits because of access to other health insurance coverage, I may be eligible to enroll myself and/or dependents in the plan, provided that I request enrollment within 31 days after my other coverage ends because of an involuntary loss (divorce, death, legal separation, termination of employment or reduction in hours worked). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll eligible dependents, provided that I request such enrollment within 31 days of the date of the qualifying event.

I understand that rates are subject to change based on a change in the group status, but I will be offered the opportunity to decline said coverage if it results in a change in the original benefits or the payroll deductions as listed above.

Additionally, I understand that elections made today will remain in place until the plan open enrollment period or I have a valid qualifying event.

Premium Only Plan Election

1. **Enrollment Type (Check One):** Effective date is September 1, 2023 or the first of the month following your date of hire or the date the enrollment form is signed. You cannot be reimbursed for expenses incurred prior to the Effective Date.

□ Annual Open Enrollment for plan year September 1, 2023 through August 31, 2024.
□ New Hire Enrollment for _____(effective date) through August 31, 2024.
□ Revised Enrollment due to Employment Status Change for_____(effective date) through August 31, 2024.
□ Revised Enrollment due to Family Status Change for _____(effective date) through August 31, 2024.

2. **Election and Contribution:** I am enrolling as follows:

□ Premium Only Plan: Money set aside in this account will be used to pay the cost of your elected health insurance premiums. I elect salary reduction in the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage for which I am eligible under the organization's group insurance plan. I understand that this is a pre-tax option and my Social Security Benefits may be reduced as a consequence of this election.
□ I do not wish to elect salary reduction, please take the necessary contribution as a post-tax salary deduction.
□ I do not wish to elect the coverage for which I am eligible and certify that I and/or my dependents are covered under another insurance plan.

3. **Authorization and Agreement:**

The required contribution amount will be taken in equal installments on an annual basis from my paychecks while I am enrolled in this plan.

I understand that this authorization is irrevocable until the next election period unless I have a qualifying event and the change I wish to make to my election is consistent with that event as specified in the Internal Revenue Code and Regulations. All changes must be reported and a new election form must be completed within 30 days of the qualifying event.

_____ _____

Employee Signature **Date Signed**