KHEO
A Keenan Solution

Class 2 – Employees

2017 Benefit Election Form

Worksite Employer: _____ Effective Date: _____

Return Completed Forms to: MMC Benefits Department via email: Benefits@MMChr.com, or Fax: **310-360-5100**, Phone: **800-899-6624**

☐ New Enrollment ☐ Open Enrollment ☐ Change of Status Date _____ ☐ Rehire Date _____
☐ Part-Time to Full-Time Employment Date _____ ☐ Family Addition ☐ COBRA ☐ Other _____

Employee Enrollment (Complete in Full)

Employee Name (Last, First, Middle Initial)	Social Security Number	Date of Hire (mm/dd/yy)

Employee Street Address Apt # City State Zip	Home Phone	Job Title

Gender ☐ M ☐ F	Date of Birth (mm/dd/yy)	Marital Status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Email

Decline Coverage: ☐ Waive Medical ☐ Waive Dental ☐ Waive Vision ☐ Waive Optional Life ☐ Waive FSA

☐ Decline Due to Other Coverage (Insurance Carrier Name): _____; or

☐ Decline Due to Other reasons: _____

Family Status Change

Date of Family Status Change Event: _____

Changes outside of Open Enrollment must be related to an event that allows for special enrollment. **Employees must submit a completed form and required documentation within 31 days of the qualifying change in family or employment status.** Check the event(s) that triggered the change:

☐ Spouse, partner, or child added due to marriage/civil union, birth, adoption, legal custody, court order, or medical support order.
☐ Spouse, partner, or child is no longer eligible dependent due to divorce, legal separation, dissolution of civil union, death, or other loss of eligibility.
☐ Dependent child attains maximum age limit.
☐ Change of eligibility due to gain or loss of coverage under another group health insurance.
☐ Change in employment status of employee, or eligible dependent or a change in residence that affects health plan availability.

Benefit Elections (Medical, Dental, Vision) – *Anthem Blue Cross*

MEDICAL

Coverage Category	Department Code: _____	Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
Anthem Premier HMO $10 copay	*Group# 279724* – _____	☐	☐	☐	☐
Anthem Premier HMO $20 copay	*Group# 279724* – _____	☐	☐	☐	☐
Anthem Premier HMO $35 copay	*Group# 279724* – _____	☐	☐	☐	☐
☐ Vivity HMO Network – for above HMO plans, check if selecting Vivity HMO Network (if offered by your employer)					
Anthem Premier PPO $250 / $15 / 10%	*Group# 279724* – _____	☐	☐	☐	☐
Anthem Classic PPO $500 / $20 / 20%	*Group# 279724* – _____	☐	☐	☐	☐
Anthem LumenosHSA $2600 / 0% / 30%	*Group# 279724* – _____	☐	☐	☐	☐
Anthem LumenosHSA $1300/2600 / 10% / 30%	*Group# 279724* – _____	☐	☐	☐	☐
Anthem LumenosHSA $3000 / 20% / 40%	*Group# 279724* – _____	☐	☐	☐	☐

DENTAL

Coverage Category		Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
Anthem Dental Complete PPO	*Group #279724* – _____	☐	☐	☐	☐
Anthem Dental Net DHMO	*Group #279724* – _____	☐	☐	☐	☐

VISION

Coverage Category		Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
Anthem Blue View Vision	*Group #279724* – _____	☐	☐	☐	☐

COVERED INDIVIDUALS

Appropriate documentation such as copy of tax return, marriage certificate or Domestic Partner (DP) affidavit, and birth certificate must be submitted upon enrollment to verify dependent eligibility.

NAME (Last, First, Middle Initial)	Coverage	Gender	For children age 26 or over: IRS Qualified Dependent?	Date of Birth	SSN#	Anthem HMO Provider ID#	Existing MD?	Dental HMO Provider ID#
SELF	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F					☐ Y ☐ N	
☐ Spouse ☐ DP Name: ☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F					☐ Y ☐ N	
Child Name ☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F	☐ Y ☐ N				☐ Y ☐ N	
Child Name ☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F	☐ Y ☐ N				☐ Y ☐ N	
Child Name ☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F	☐ Y ☐ N				☐ Y ☐ N	
Child Name ☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F	☐ Y ☐ N				☐ Y ☐ N	

COBRA COVERAGE INFORMATION – COMPLETE ONLY IF ENROLLING IN COBRA

Reason for COBRA coverage

Federal COBRA qualifying event date	Federal COBRA coverage begin date	Federal COBRA coverage end date

PRIOR COVERAGE (for PPO Plans Only)

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Self					
☐ Spouse ☐ DP					
Child					
Child					

Coordination of Benefits: Do you or your dependents have other health plan or health insurance (including Medicare)? Yes ☐ No ☐

Is the other coverage primary? Yes ☐ No ☐

If yes, please provide the following information on the person & health plan providing other coverage:

Subscriber Name: ____**Effective Date:**____

Carrier Name: ____**Group/Policy #:**__________________

BASIC LIFE AND AD&D - *Anthem Blue Cross Life & Health* | Life Class 2 #279724C002 / AD&D Class 2 #279724B002

Your employer provides a Basic Life and Accidental Death & Dismemberment benefit of 1 x Base Annual Salary, up to a maximum of $100,000. Benefit reduces by 35% at age 65; 50% at age 70. *Human Resources Entry Only* - Annual Salary: $ ________________ ☒ Elect

OPTIONAL LIFE - *Anthem Blue Cross Life & Health*	**Employee Only #279724S001 / Employee + Spouse #279724SF01** **Employee + Child(ren) #279724SF01 / Employee + Spouse + Child(ren) #279724SF01**

Additional Optional Life Insurance is available for you and your dependents. **An Evidence of Insurability Form for each applicant must be completed and approved for Optional Life amounts elected above the Guarantee Issue amount, and for enrollments or increases after your initial enrollment period.** Benefit availability is subject to participation minimum.

Employee Optional Coverage	**Spouse/DP Optional Coverage**	**Child(ren) Optional Coverage**
$10,000 increments, max lesser of 5 x Salary or $500,000 Guarantee Issue: $50,000	$5,000 increments, max $250,000 *(Not to exceed 50% of Employee Optional Coverage)* Guarantee Issue: $25,000	Flat $5,000 or $10,000 per unit
Employee Optional Coverage Amount $ _____	**Spouse/DP Optional Coverage Amount** $ _____	**Child(ren) Optional Coverage Amount** ☐ $5,000 ☐ $10,000

FLEXIBLE SPENDING ACCOUNTS (FSA) & HEALTH SAVINGS ACCOUNT (HSA) - *TASC*

Once enrolled in an FSA or HSA account, you may not change your contribution until the next Open Enrollment unless a qualifying family status change occurs. You must make a new election each year. *Highly Compensated Individuals (earning $120,000 a year or more as defined by IRS) are not eligible to participate in the pre-tax FSA plans, but are eligible to participate in the Health Savings Account (HSA).*

If you would like to participate in an FSA or HSA account, you must annually complete a new TASC Enrollment Form.

Flexible Spending Account – Healthcare FSA ($2,600/year max) ☐ **Elect, TASC enrollment form attached**	Dependent Daycare Spending Account ($5,000/year max per household; $2,500/year max if married filing separately) ☐ **Elect, TASC enrollment form attached**	Health Savings Account – HSA (Max $3,400/year individual, $6,750 family)* Must be enrolled in HSA compatible medical plan ☐ **Elect, TASC enrollment form attached**
Mass Transit Account ($255/month max) ☐ **Elect, TASC enrollment form attached**	Parking Reimbursement Account ($255/month max) ☐ **Elect, TASC enrollment form attached**	Limited Purpose Flexible Spending Account ($2,500/year max; can be paired with HSA) ☐ **Elect, TASC enrollment form attached**

*To be eligible to contribute to a Health Savings Account (HSA), you must be enrolled in an HSA compatible medical plan, known as a High Deductible Health Plan (HDHP), and you may not be enrolled in any other coverage that is not an HSA compatible plan (such as HMO, non-high deductible PPO, or FSA through yourself or spouse). Consult with your tax advisor if you are unsure of your eligibility to contribute to an HSA.

FLEX SPENDING ACCOUNT NOTICE *Ending Employment (or Other Loss of Eligibility)*:
If your eligibility to participate in the health FSA ends due to your termination of employment or otherwise, your participation in the FSA ends on your date of termination. In some cases participation may continue under COBRA, the federal law providing for limited continuation of health insurance coverage. You might consider continuing your coverage under COBRA if, for instance, on the date you lost eligibility you have a positive account balance (you've contributed more than you've withdrawn for the plan year) and you have planned to incur, later in the year, medical expenses that won't be covered by insurance.

You may only submit claims for eligible expenses incurred through the last date of participation in the plan, either as an active employee or, where applicable, under COBRA. Expenses incurred after this date are not eligible for reimbursement. If upon the termination of your eligibility to participate in FSA you are entitled to continue coverage under COBRA, you will receive a written notice explaining the procedure for continuing your participation. If you qualify for COBRA coverage you must continue to make your regular monthly premium payment (plus two percent to cover administrative costs) on an after-tax basis. In no event will COBRA coverage continue beyond the end of the FSA's plan year (January1 – December 31) in which your loss of eligibility occurred.

SIGNATURE REQUIRED ON BOTH SECTIONS OF FOLLOWING PAGES

SIGNATURE REQUIRED

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1 The date eligibility for COBRA Continuation Coverage ends, or

2 The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or

3 The date your employer discontinues coverage with Anthem Blue Cross, or

4 The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or

5 The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

As part of the W–9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Employee Signature	Date	**HR Use Only** Entered:

Signature Required for Anthem Blue Cross Plan Enrollees **Date**

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements. I also certify that the information I provided on this form and at all times during coverage about my family status and my dependents' eligibility for benefits under the benefit plan is accurate. I understand that coverage may be rescinded in the event of fraud or a material misrepresentation, and such rescission is effective on the date of such fraud or misrepresentation.

FRAUD WARNING: I further understand that any person who knowingly, and with intent to defraud any insurance company, or other person, files an application for insurance or a statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DEDUCTION AUTHORIZATION: I authorize my employer to deduct from my wages the required subscription charges/premiums on a pre-tax basis as determined by the benefits that I have chosen. If my employment terminates, I authorize my employer to make any required payroll deductions associated with my benefit elections from my final paycheck. I understand that the benefits that I have elected will be in effect through December 31, 2017 or until a new election is received due to a qualifying family status change or subsequent open enrollment period. **I understand I have 30 days from the qualifying event to notify the MMC Benefits Department. I also am responsible for notifying MMC of dependents that are no longer eligible within 30 days of the qualifying event. Failure to do so may jeopardize my dependent's right to elect COBRA.**

LEAVE OF ABSENCE: If you are on an approved federal or state leave of absence, you may choose to continue participation during your leave by making payments directly to us. This will allow you to submit eligible expenses incurred during your leave. If you do not continue to make direct payments during your approved leave of absence, your participation under the plan ends at the end of the pay period in which your last contribution is deducted from your paycheck. Please contact the MMC Benefits Department at (800) 899-6624 if you become aware of the need for a leave of absence so we can explain the options available.

_____ _____

Employee Signature Required **Date**

Beneficiary Designation Form

Return Completed Forms to: MMC Benefits Department via email: **Benefits@MMChr.com**, Fax: **310-360-5100**, Phone: **800-899-6624**

Select one of the following:

- ☐ Designation for Group Life Policy Only
- ☐ Designation for Supplemental Life Policy Only
- ☐ Designation for both Group and Supplemental Life Policies

Insured First Name	Middle Name	Last Name	
Insured Street Address	City	State	Zip
Insured Social Security Number	Home Phone	Cell Phone	Date of Birth (dd/mm/yyyy)
Insured Home Email		Worksite Employer	

Definitions/Statements: Primary Beneficiary means the person or persons who will receive the benefits in the event of the Insured's death. Proceeds will be divided in equal shares if multiple beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%. Contingent Beneficiary means the person or persons who will receive the benefits if the primary beneficiary is not living at the time of the Insured's death. Proceeds will be divided in equal shares if multiple beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%.

Beneficiary Information

Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				☐ Primary ☐ Contingent	% Designation
Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				☐ Primary ☐ Contingent	% Designation
Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				☐ Primary ☐ Contingent	% Designation
Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				☐ Primary ☐ Contingent	% Designation
Other – Estate of Insured, Revocable or Irrevocable Trust, and Trustee Under Insured's Will				☐ Primary ☐ Contingent	% Designation

Should I survive all of the persons named on this form, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to MMC all in accordance with the applicable provisions of law. **BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE PREVIOUS DESIGNATION I MAY HAVE FILED.**

Insured Signature	Date