QUILEUTE TRIBAL COUNCIL
EMPLOYEE HEALTH CARE ENROLLMENT FORM

TO BE COMPLETED BY EMPLOYER:

Date of Hire _____ **Effective Date** _____

Monthly Salary _____ **Division** _____

PLEASE CHECK THE APPROPRIATE BOXES**:**

❒ New Employee ❒ Change ❒ Open Enrollment

For Currently Enrolled Employees Mark Reason for Enrollment Change Below: Date of Change _____

❒ Birth ❒ Adoption ❒ Marriage ❒ Divorce ❒ Death ❒ Address Change ❒ Name Change ❒ Beneficiary Change
❒ Involuntary Loss of Coverage (Complete Medical/Dental Enrollment Information)

❒ Other - Explain _____

GENERAL INFORMATION

Name of Employee (Last, First, M.I.) _____ Social Security# _____

Date of Birth _____

Employee Residence: _____ _____ _____ _____
Street or P.O. Box City State Zip

Home Phone #: (__) _____ Cell Phone #: (___) _____ Weekly Hours Worked _____

MEDICAL, DENTAL AND VISION ENROLLMENT INFORMATION **PLEASE LIST YOURSELF AND ALL DEPENDENTS TO BE COVERED**

Add	Delete	Name (Last, First, MI)	Social Security Number	Sex	Birthdate	Relationship	Quileute Native (Q) Other Native (O) Non-Native (N)	CHS/PRC Y/N
☐	☐					SELF		
☐	☐							
☐	☐							
☐	☐							
☐	☐							

	MEDICAL PLAN	DENTAL PLAN	VISION PLAN
	Per paycheck		Combined with Medical plan cost
Employee	$25.00		
Employee & Child(ren)	$75.00		
Employee & Spouse	$75.00		
Employee & Domestic Partner (Post-Tax)	$75.00		
Employee, Spouse & Child(ren)	$75.00		
Employee, Domestic Partner & Child(ren) (Post-Tax)	$75.00		

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
EMPLOYER PAID LIFE/AD&D BENEFICIARY DESIGNATION
In the event of my death, all proceeds from my employer paid survivor benefits provided through Quileute Tribal Council shall be paid to the beneficiary designated below.

You are automatically enrolled in the Employer paid Life/AD&D and Short-Term Disability (STD) plans offered.
IT IS MANDATORY THAT YOU ESTABLISH A BENEFICIARY DESIGNATION BELOW:

Beneficiary (Full Name) ❒ Primary ❒ Secondary Split % ___ (Address):	Relationship	Date of Birth	Social Security Number
Beneficiary (Full Name) ❒ Primary ❒ Secondary Split % ___ (Address):	Relationship	Date of Birth	Social Security Number
Beneficiary (Full Name) ❒ Primary ❒ Secondary Split % ___ (Address):	Relationship	Date of Birth	Social Security Number
Beneficiary (Full Name) ❒ Contingent (if applicable) (Address):	Relationship	Date of Birth	Social Security Number
Beneficiary (Full Name) ❒ Contingent (if applicable) (Address)	Relationship	Date of Birth	Social Security Number

❒ I elect spouse coverage ($10,000 Life only, no AD&D)

Date of Birth _____ Social Security Number _____

❒ I elect child coverage ($2,000 for children 6 months to age 26; $500 for children infant to 6 months. Life only, no AD&D)

Date of Birth _____ Social Security Number _____

IF YOU AND YOUR SPOUSE ARE BOTH EMPLOYEES OF QUILEUTE, YOU MAY NOT ELECT SPOUSE COVERAGE. YOU WILL BOTH BE ENROLLED ON THE EMPLOYEE ONLY COVERAGE. IF YOU HAVE CHILD(REN), ONLY ONE PARENT MAY ENROLL THE CHILD(REN) ON THEIR LIFE INSURANCE COVERAGE, NOT BOTH PARENTS

Critical Illness Insurance:

Please circle option if electing, leave blank if declining coverage

Rates for $10,000 of coverage:

Attained Age Uni-Tobacco Monthly Premium Rates for $10,000 Coverage Amount				
Age	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
18-24	$3.29	$4.96	$4.51	$6.37
25-29	$4.07	$6.10	$5.28	$7.51
30-34	$4.62	$6.92	$5.84	$8.33
35-39	$6.20	$9.27	$7.41	$10.68
40-44	$9.17	$13.78	$10.38	$15.19
45-49	$14.79	$22.44	$16.00	$23.85
50-54	$21.05	$32.14	$22.26	$33.55
55-59	$29.13	$44.70	$30.34	$46.12
60-64	$41.37	$63.69	$42.59	$65.10
65-69	$57.27	$87.91	$58.48	$89.32
70-74	$76.43	$117.30	$77.64	$118.72
75-79	$100.40	$153.71	$101.61	$155.12

Critical Illness Insurance *(continued)*

Please circle option if electing, leave blank if declining coverage:

Rates for $20,000 of coverage:

Attained Age Uni-Tobacco Monthly Premium Rates for $20,000 Coverage Amount				
Age	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
18-24	$6.59	$9.91	$7.80	$11.33
25-29	$8.14	$12.20	$9.36	$13.61
30-34	$9.25	$13.84	$10.46	$15.25
35-39	$12.39	$18.54	$13.60	$19.95
40-44	$18.34	$27.56	$19.55	$28.97
45-49	$29.58	$44.88	$30.79	$46.29
50-54	$42.10	$64.28	$43.32	$65.70
55-59	$58.25	$89.41	$59.46	$90.82
60-64	$82.75	$127.37	$83.96	$128.78
65-69	$114.54	$175.82	$115.75	$177.23
70-74	$152.87	$234.61	$154.08	$236.02
75-79	$200.81	$307.42	$202.02	$308.83

Accident Insurance

Please circle option if electing, leave blank if declining coverage:

Rates are as follows. Accident insurance has a benefit payment range of $25 to $30,000, depending on nature and severity of accident:

Monthly Rate Information:				
PLAN TYPE	**Employee**	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
MONTHLY RATES – PLAN 2	**$14.99**	**$23.65**	**$25.53**	**$40.01**
INITIAL RATE GUARANTEE PERIOD	2 Years			

ID Theft Protection

Please circle option if electing, leave blank if declining coverage:

IDENTITY THEFT PROTECTION COVERAGE (INFOARMOR)	
	Monthly Cost
Employee	$9.95
Employee & Spouse	$17.95
Employee & Child(ren)	$17.95
Employee, Spouse & Child(ren)	$17.95

Pet Insurance

Please circle deductible option if electing, leave blank if declining coverage. Please complete pet's information if electing also. You may choose different deductibles for different pets. Please indicate deductible for each pet.

MONTHLY COST						
	$75 Deductible		$250 deductible		$500 deductible	
Pet Age	Dog	Cat	Dog	Cat	Dog	Cat
8 weeks – 2 years	$47.24	$19.03	$37.92	$15.28	$29.15	$11.74
3-5 years	$57.99	$19.58	$46.56	$15.72	$35.79	$12.08
6-7 years	$75.00	$27.94	$60.21	$22.43	$46.28	$17.24
8-10 years	$105.26	$34.55	$84.51	$27.74	$64.96	$21.32
11+ years	$118.66	$71.85	$95.26	$57.68	$73.22	$44.34

PET INSURANCE COVERAGE (TRUPANION)							
Type of Pet	Name of Pet	Age of Pet today	Pet Birth Date	Primary Breed	Gender	Spayed/ Neutered	Deductible Selection

DEDUCT MY MEDICAL, DENTAL AND VISION PREMIUM PRE-TAX, IF APPLICABLE. ☒ Yes ❒ No

I understand that once I make an initial election to have my health insurance premiums paid for using pre-tax dollars, **that election will remain in force from plan year to plan year**. Each plan year I will be notified in writing of the upcoming renewal of the plan and if I want to change my election, I must complete a new enrollment form. Otherwise, my election will remain as previously elected.

I hereby apply for the employer-paid benefits and other benefits as elected on this enrollment form and the terms contained therein. I agree that if this application includes persons in addition to myself, that such persons are my lawful and/or eligible dependents. Legal documentation is attached for court-appointed wards.

I agree that falsification of any statement in this application which materially affects the acceptance of this contract may bar the right to services under the contract. I hereby authorize any of the carriers underwriting benefits, or their producers, to examine any physicians, hospitals, or insurance carrier's records concerning me or my dependents listed hereon.

I authorize the Social Security Administration to furnish any insurance company, health service contractor or Health Maintenance Organization underwriting Medical and/or Dental benefits through a contract with my employer, medical or other information acquired by it under Title XVII Program (Medicare) to the extent necessary to process any claim under the agreement in effect with the aforementioned benefit underwriters should I or any of my dependents become eligible.

I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I authorize deductions from my earnings to cover my contribution, if required towards the cost of my benefits.

TO BE COMPLETED BY EMPLOYER:

I agree to have the company reduce my bi-weekly (deductions are taken twice monthly unless there are 3 pay dates in the month) pay by the amount I am required to contribute toward my employee benefits throughout the Plan Year. The amount of reduction will automatically change in the event a change occurs in the contribution amount.

➔ X _____ _____

EMPLOYEES SIGN HERE. Do not print. Date Signed

Note: Please sign and date even if no dependent plan deductions.