QUILEUTE TRIBAL COUNCIL EMPLOYEE HEALTH CARE ENROLLMENT FORM

TO BE COMPLETED BY EMPLOYER: Date of Hire _____ **Effective Date** _____

PLEASE CHECK THE APPROPRIATE BOXES:

❒ Council ❒ Enterprise ❒ Housing Annual Salary $ _____ Hourly Rate $_____ Hours per Week _____

❒ New Employee ❒ Change ❒ Open Enrollment Title_____.

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

❒ Other - Explain _____. ❒ **WAIVE COVERAGE** – Explain _____.

EMPLOYEE INFORMATION

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

Employee Mailing Address: _____ _____ _____ _____

Street or P.O. Box City State Zip

Home Phone #: _____ Cell Phone #: _____ Email Address _____

DEPENDENT INFORMATION

PLEASE LIST YOURSELF AND ALL DEPENDENTS TO BE COVERED

Add	Delete	Name (Last, First, MI) *	Social Security Number	Gender M or F	Birthdate	Relationship Spouse (S) Child (C)	Quileute Native (Q) Other Native (ON) Non-Native (NN)	PRC USE ONLY Y/N	PRC EFFECTIVE DATE
☐	☐					**SELF**			
☐	☐								
☐	☐								
☐	☐								
☐	☐								

PRC Signature Date

If you have medical coverage through another source, please complete the following information:

Provide the following information on the other medical coverage: ☐ Individual Policy ☐ Group/Employer Policy ☐ Medicaid **Effective Date** _____

Subscriber's Name: _____ Subscriber's Relationship: _____ Subscriber's Employer's Name: _____

Carrier Name: _____ Group Number: _____ Policy Number: _____ _____ _____

Is Employee, Spouse/Domestic Partner covered under the Quileute Tribal Council medical plan eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility for Medicare Part A _____ Medicare Part B _____

Please note – if you are waiving **Quileute Tribal Council's** coverage because you are receiving a premium subsidy on an individual policy through the state or federal Exchange, be aware that **Quileute Tribal Council** meets the criteria for offering an affordable plan that means minimum essential coverage and minimum value under the ACA. This means that if you waive **Quileute Tribal Council's** coverage and keep the individual policy, you may become ineligible for the premium subsidy.

QUILEUTE TRIBAL COUNCIL EMPLOYEE HEALTH CARE ENROLLMENT FORM

EMPLOYEE MEDICAL, DENTAL AND VISION CONTRIBUTION SCHEDULE

Enroll Employee in Employer Paid: **BASIC LIFE ☐ EAP ☐ LTD ☐ STD ☐**	**MEDICAL, DENTAL & VISION**	**ACCIDENT**	**ID THEFT**	**CRITICAL ILLNESS**	**VOLUNTARY LIFE and AD&D** EE $ SP $ Child $	**1.BASIC LIFE 2.LTD 3.STD 4.EAP** (HR ONLY)
(Please check based on coverage elected)	PER PAYCHECK	PER MONTH	PER MONTH	PER MONTH	PER MONTH	
Employee	☐ **$25.00**	☐ **$14.99**	☐ **$9.95**	**$**	**$**	**1.$**
Employee & Spouse or w/Domestic Partner (**Post-Tax**)	☐ **$75.00**	☐ **$23.65**	☐ **$17.95**	**$**	**$**	**2.$**
Employee & Child(ren)	☐ **$75.00**	☐ **$25.53**	☐ **$17.95**	**$**	**$**	**3.$**
Employee Family (w/Domestic Partner) (**Post-Tax**)	☐ **$75.00**	☐ **$40.01**	☐ **$17.95**	**$**	**$**	**4.$**
Spouse Coverage ($10,000 Life Only, no AD&D) Child Coverage ($2,000 for children 6 months to age 26; $500 for infants to 6 months. Life only no AD&D per child unit)	☐ **$2.00 per family unit**	**Date of Marriage _____**				

DEDUCT MY MEDICAL, DENTAL, OR 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.

➔ X_____ _____

EMPLOYEES SIGN HERE. Do not print. Date Signed

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

QUILEUTE TRIBAL COUNCIL EMPLOYEE HEALTH CARE ENROLLMENT FORM

ACCIDENT AND ID THEFT

Please check if electing, leave blank if declining coverage:

Accident Insurance

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

ID Theft – Allstate Identity Protection

Monthly Rates		Accident Insurance		ID Theft Protection
Employee	☐	$14.99	☐	$9.95
Employee & Spouse	☐	$23.65	☐	$17.95
Employee & Child(ren)	☐	$25.53	☐	$17.95
Family	☐	$40.01	☐	$17.95

CRITICAL ILLNESS INSURANCE

Please check if electing, leave blank if declining coverage:

Benefit Amount $10,000

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

Benefit Amount $20,000

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

Rates are based on the attained age of the Employee and increase as he/she enters each new age category

QUILEUTE TRIBAL COUNCIL EMPLOYEE HEALTH CARE ENROLLMENT FORM

VOLUNTARY LIFE and AD&D INSURANCE

Please check if electing, leave blank if declining coverage:

EMPLOYEE Benefit Amount 5 times salary up to $100,000 in increments of $10,000

SPOUSE Benefit Amount $30,000 in increments of $5,000

CHILD Benefit Amount $10,000

Rate Per $1,000			Child 0-26	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
	Amount		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
EMPLOYEE LIFE	$	☐		$0.097	$0.081	$0.088	$0.114	$0.154	$0.226	$0.331	$0.473	$0.639	$0.918	$1.592	$4.384
SPOUSE LIFE	$	☐		$0.097	$0.081	$0.088	$0.114	$0.154	$0.226	$0.331	$0.473	$0.639	$0.918	$1.592	$4.384
CHILD LIFE (Per child unit)	$	☐	$2.00												

Rates are based on the attained age of the Employee and increase as they enter each new age category

QUILEUTE TRIBAL COUNCIL EMPLOYEE HEALTH CARE ENROLLMENT FORM

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
EMPLOYER PAID LIFE/AD&D and VOLUNTARY LIFE BENEFICIARY DESIGNATION

In the event of my death, all proceeds from my employer paid survivor benefits and voluntary insurance benefits provided through Quileute Tribal Council shall be paid to the beneficiary designated below.

You are automatically enrolled in the Basic Life/AD&D, Short-Term (STD), and Long-Term Disability (LTD) plans offered.

IT IS MANDATORY THAT YOU ESTABLISH A BENEFICIARY DESIGNATION BELOW:

Beneficiary ❒ Primary ❒ Secondary Split% _____	Relationship	Date of Birth	Social Security Number
(Full Name)			
(Address):			
Beneficiary ❒ Primary ❒ Secondary Split% _____	Relationship	Date of Birth	Social Security Number
(Full Name)			
(Address):			
Beneficiary ❒ Primary ❒ Secondary Split% _____	Relationship	Date of Birth	Social Security Number
(Full Name)			
(Address):			
Beneficiary ❒ Primary ❒ Secondary Split% _____	Relationship	Date of Birth	Social Security Number
(Full Name)			
(Address):			

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