# Miller & Long
# Insurance Enrollment Benefit Plan
## Hourly | Salary

| Office Use Only | | | |
|---|---|---|---|
| Employee ID | Hire Date | Effective Date | Job Site |
| | | | |
| ☐ New Applicant ☐ Open Enrollment ☐ Qualifying Event | | | |
| **Payroll Use Only** | | | |
| ☐ New Hire ☐ Rehire ☐ Hourly ☐ Salary | | | |
| Employee No. | | Job Site No. | D.O.H |
| | | | |

| Last Name | First Name | MI | Social Security Number |
|---|---|---|---|
| | | | |
| Address | City | State | Zip |
| | | | |
| Phone Number | Date of Birth | Gender ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married |
| | | | |

**Health Plan Kaiser Permanente HMO Medical/RX Plan** ☐ **Yes** ☐ **No, I decline.**

**Voluntary Delta Dental Plan (Check one)** ☐ **Yes** ☐ **No, I decline.**

**Voluntary Vision EyeMed Plan (Check one)** ☐ **Yes** ☐ **No, I decline.**

If you checked **Yes**, select an option from the tier options below:

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family Coverage

Other Group Health Coverage

Do you or your spouse participate in any other group health plan, including an HMO or Government plan including Medicare? ☐ **Yes** ☐ **No**

Name of Plan:
ID Number:
Phone Number:

**Do you have dependents? Supporting Documents Required** ☐ Spouse Only ☐ Spouse & Children ☐ Children Only ☐ No Dependents

| Last Name | First Name | Date of Birth | Health Benefits | Social Security No. | Relationship |
|---|---|---|---|---|---|
| | | | ☐ Yes ☐ No | | ☐ Spouse |
| | | | ☐ Yes ☐ No | | ☐ Daughter ☐ Son |
| | | | ☐ Yes ☐ No | | ☐ Daughter ☐ Son |
| | | | ☐ Yes ☐ No | | ☐ Daughter ☐ Son |
| | | | ☐ Yes ☐ No | | ☐ Daughter ☐ Son |
| | | | ☐ Yes ☐ No | | ☐ Daughter ☐ Son |

**Employee Contribution**

I hereby elect to participate in the Plan and choose to convert a portion of my salary into the applicable pre-tax contributions for the health coverage I have elected above. This election form will be deemed to apply to all succeeding plan years unless the Company is notified in writing prior to each November 1. I understand that if there is a significant change in the cost of health coverage under the Plan, the Employer may increase automatically, during a Plan Year, the payroll deductions I am required to make per pay period to purchase the health benefits I have elected above. I understand further that the payroll deduction elections set forth above will continue in effect notwithstanding any reductions in the health benefits I have elected above. In addition, I understand that, except in certain cases involving a significant reduction in health coverage or a significant increase in the cost of health coverage under the Plan for which the Employer permits me to change my health coverage elections, I may change the above elections only (i) if I experience a "status change", as defined under the applicable law, and if my change in elections is consistent with that "status change", (ii) if I exercise Special Enrollment Period Rights (as described in the Notice of Special Enrollment Periods that accompanies this Election Form), (iii) if I qualify to make another election change because of a change in cost or coverage or for certain other reasons, as permitted under the Plan, or (iv) during an Open Enrollment period. I understand that the elections noted above may need to be modified by the Employer to insure that the Plan complies with applicable tax rules.

**Employee Signature** **Date**

Original – HR Insurance Department Copy – Payroll Department Copy – Employee