AGC Health Benefit Trust
OREGON COLUMBIA CHAPTER

# EMPLOYEE ENROLLMENT FORM

**Group Name:** _____

**Medical Plan:** _____

| **EMPLOYER INFORMATION (TO BE COMPLETED BY HR)** | | |
|---|---|---|
| Enrollment (check one): ❑ New Enrollment ❑ Change of Enrollment Status | | Effective Date of Insurance/Change: |
| Enrollment/Change Reason:<br>❑ New Employee ❑ Rehired Employee ❑ Open Enrollment ❑ Transfer from Other Plan ❑ Involuntary Loss of Other Coverage (Prior Coverage Certificate required)<br>❑ Marriage ❑ Divorce ❑ Adoption (Legal Documents May be Required) ❑ Dependent Change<br>Date of Event: | | |
| Date of Hire: | Date Employee Entered Eligible Class or Satisfied Non-Time Lapse Based Wait (if not date of hire): | Employee Class: |
| Employee Annual Salary: $ | Employee Hours Worked Per Week: | Job Title: |

| **EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)** | | |
|---|---|---|
| Employee Name: | ❑ Married ❑ Unmarried | Phone: |
| Mailing Address: | City: State: | Zip: |

| Add | Drop | Relationship to Employee | Name (Last, First, MI) | Social Security Number (required) | Date of Birth | Gender | |
|---|---|---|---|---|---|---|---|
| | | | | | | Male | Female |
| ❑ | ❑ | Self | | | | | |
| ❑ | ❑ | Spouse/Domestic Partner | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |
| ❑ | ❑ | | | | | | |

Is any child, over the dependent age limit of 26, applying for coverage due to disability? ❑No ❑Yes If yes, see Human Resources for additional paperwork.

| BENEFIT PLAN SELECTION (TO BE COMPLETED BY EMPLOYEE) Please only choose one election each for medical, vision and dental. | | | | | |
|---|---|---|---|---|---|
| Regence BCBS – Medical/Rx Plan (REQUIRED) | ❑ Employee Only | ❑ Employee + Spouse | ❑ Employee + Child(ren) | ❑ Employee + Family | ❑ Decline |
| LifeMap Life/AD&D (REQUIRED) | ❑ Employee Only | *Employees can only decline the Basic Life/AD&D if they are declining the medical insurance AND their employer has elected to only offer life coverage to employees who are also enrolled in the medical insurance. | | | ❑ Decline* |

Beneficiary for Employee's Basic Life/AD&D Insurance:

| Beneficiary Name | Relationship | Address | Benefit % |
|---|---|---|---|
| | | | |
| | | | |

| | | | | | |
|---|---|---|---|---|---|
| The Standard (VSP) – Group Vision Plan | ❑ Employee Only | ❑ Employee + Spouse | ❑ Employee + Child(ren) | ❑ Employee + Family | ❑ Decline |
| The Standard – Dental Plan | ❑ Employee Only | ❑ Employee + Spouse | ❑ Employee + Child(ren) | ❑ Employee + Family | ❑ Decline |
| **VOLUNTARY BENEFIT PLAN SELECTION (TO BE COMPLETED BY EMPLOYEE) Please only complete this section if your employer has elected one of these products.** | | | | | |
| The Standard (VSP) – Voluntary Vision Plan | ❑ Employee Only | ❑ Employee + Spouse | ❑ Employee + Child(ren) | ❑ Employee + Family | ❑ Decline |
| LifeMap – Voluntary Employee Life Insurance<br>(Please refer to LifeMap benefit and rate sheet for details on available life insurance increments and maximums.) | ❑ Employee<br>Amount Requested: $ | ❑ Spouse<br>Amount Requested: $ | ❑ Child(ren)<br>Amount Requested: $ | | ❑ Decline |
| | ***Please also complete "LifeMap Voluntary Benefits Employee Enrollment and Change Form."*** | | | | |
| LifeMap – Voluntary Employee Accident Insurance | Individual:<br>❑ Employee<br>❑ Spouse<br>❑ Child | ❑ Employee + Spouse | ❑ One Parent + Child(ren)<br>Parent Election:<br>❑ Self<br>❑ Spouse/Domestic Partner | ❑ Employee + Family | ❑ Decline |
| | ***Please also complete "LifeMap Voluntary Benefits Employee Enrollment and Change Form."*** | | | | |
| Consumer Driven Health Plan Administration<br>(Please also complete and attached the appropriate BSI enrollment form.) | ❑ Flexible Spending Account (FSA) | ❑ Health Reimbursement Account (HRA) | ❑ Health Savings Account (HSA) | ❑ Dependent Care Assistance Plan (DCAP) | ❑ Decline |

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. AGC Health Benefit Trust, BSI, and The Insurance Companies may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. The Insurance Companies may also disclose PPI to state and/or federal agencies, or other third parties, as required by law.

Employee Signature Print Name: Date:

# Special Enrollment Notice

Under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be eligible, in certain situations, to enroll in a medical benefit offered under the Associated General Contractors Health Benefit Trust (the "Trust") during the year, even if you previously declined coverage. This right extends to you and all eligible family members.

You will be eligible to enroll yourself and eligible family members in the Trust if, during the year, you or your family members have lost coverage under another plan for any of these reasons:

- Coverage ended due to termination of employment, divorce/termination of life partnership, death, loss of dependent status or a reduction in hours that affected benefits eligibility;
- Coverage because you or your dependents no longer live or work in a plan's service area;
- Employer contributions to the plan stopped;
- The plan was terminated or discontinued; or,
- COBRA coverage ended

If you gain a new family member during the year as a result of marriage/commencement of life partnership, birth, adoption or placement for adoption, you may enroll that family member, as well as yourself and any other eligible family members in the Trust, even if you previously declined medical coverage.

Please note that special enrollment rights will be extended only if you notify Benefit Solutions, Inc. at (877) 694-8291 within 30 days of the event.

Additional special enrollment rights are available if you or your dependents:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- Become newly eligible for a state premium assistance program for qualifying child to pay for an employer health plan.

To qualify, you must notify Benefit Solutions, Inc. at (877) 694-8291 within 60 days of the Medicaid/CHIP qualifying event.

If you meet any of the above requirements, you will be allowed one of these options:

- Enroll your dependents in your current medical coverage; or
- Enroll in any medical plan option for which you and your family members are eligible.