



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:

New Employee Rehired Employee Open Enrollment Transfer from Other Plan Involuntary Loss of Other Coverage (Prior Coverage Certificate required)

Marriage Divorce Adoption (Legal Documents May be Required) Dependent Change

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: _____
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Employee Annual Salary: \$ _____	Employee Hours Worked Per Week: _____	Job Title: _____
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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
<input type="checkbox"/>	<input type="checkbox"/>	Self					
<input type="checkbox"/>	<input type="checkbox"/>	Spouse/Domestic Partner					
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

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)	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Decline
LifeMap Life/AD&D (REQUIRED)	<input type="checkbox"/> 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.			<input type="checkbox"/> Decline*
Beneficiary for Employee’s Basic Life/AD&D Insurance:					
Beneficiary Name	Relationship	Address			Benefit %
The Standard (VSP) – Group Vision Plan	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Decline
The Standard – Dental Plan	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> 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	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Decline
LifeMap – Voluntary Employee Life Insurance (Please refer to LifeMap benefit and rate sheet for details on available life insurance increments and maximums.)	<input type="checkbox"/> Employee Amount Requested: \$	<input type="checkbox"/> Spouse Amount Requested: \$	<input type="checkbox"/> Child(ren) Amount Requested: \$	<input type="checkbox"/> Decline	
	<i>Please also complete “LifeMap Voluntary Benefits Employee Enrollment and Change Form.”</i>				
LifeMap – Voluntary Employee Accident Insurance	Individual: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Employee + Spouse	Parent Election: <input type="checkbox"/> One Parent + Child(ren) <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Decline
	<i>Please also complete “LifeMap Voluntary Benefits Employee Enrollment and Change Form.”</i>				
Consumer Driven Health Plan Administration (Please also complete and attached the appropriate BSI enrollment form.)	<input type="checkbox"/> Flexible Spending Account (FSA)	<input type="checkbox"/> Health Reimbursement Account (HRA)	<input type="checkbox"/> Health Savings Account (HSA)	<input type="checkbox"/> Dependent Care Assistance Plan (DCAP)	<input type="checkbox"/> 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.