Cheyenne Regional Medical Center
2014 Benefit Enrollment/Change Form

Health/Dental/Vision/Life, AD&D and Flexible Benefits

EFFECTIVE DATE:_____

Enrollment form must be submitted within **30 days of the Date of Hire** or within 30 days of a qualifying event. See Human Resources for more information on qualifying events and related enrollment periods.

[ ] New Hire Enrollment
[ ] Change of Enrollment Reason _____
[ ] Adding/Deleting Dependents Reason _____

EMPLOYEE ENROLLMENT INFORMATION (Please complete all sections)

Employee Name (Last, First, MI):			Social Security Number:	
Mailing Address			City, State, Zip, Country:	
Sex:	Marital Status	Date of Birth	Date of Hire:	Hours worked per week:
Title/Occupation:		Home Phone:	Work Phone:	E-Mail:

DEPENDENT INFORMATION

Name (Last, First, MI)	Sex	Date of Birth	Social Security Number #	Add/ Delete
[ ] Spouse [ ] Domestic Partner*				
Child				
Child				
Child				

*Employees enrolling a domestic partner must attach a completed Domestic Partner Affidavit.

OTHER INSURANCE COVERAGE INFORMATION ***(Coverage for Pre-Existing Conditions Will Be Based On This Information).***

1. Are you currently or have you recently been covered under a COBRA continuation policy? [ ] Yes [ ] No
2. Is your spouse/ domestic partner covered under COBRA? [ ] Yes [ ] No [ ] N/A
3. Are your covered dependent children covered under COBRA? [ ] Yes [ ] No [ ] N/A
4. Have you or any of your dependents been covered under any other form of health insurance during the past 12 months?[ ] Yes [ ] No

Please list below all other health coverage you and your eligible dependents have had in the past 12 months:

Myself _____Insurance Carrier _____Dates of Coverage __/____to____/____
Spouse/
Domestic Partner _____Insurance Carrier _____Dates of Coverage __/____to____/____

Child _____ Insurance Carrier_____Dates of Coverage ___/____to____/___

Child _____Insurance Carrier_____Dates of Coverage ___/____to____/___

Child _____Insurance Carrier_____Dates of Coverage ___/___ to____/___

LIFE AND AD&D INSURANCE BENEFICIARY DESIGNATION

	Name (Last, First, MI)	Social Security Number	Relationship to Employee
Primary Beneficiary			
Secondary Beneficiary			

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Premiums - All **eligible** premiums are automatically pre-tax. Payroll deductions for Flex Spending Accounts come out of 26 pay periods per year. Payroll deductions for Medical, Dental and Vision premiums come out of the first two pay periods of each month.(24 pay periods per year)

HEALTH INSURANCE ENROLLMENT

Coverage Selection: [ ] Employee only [ ] Employee + Spouse/Domestic Partner [ ] Employee + Child(ren) [ ] Family
Plan Selection:

[ ] BestLife Plus - Medical and Prescription Drug Plan
[ ] BestLife Basic - Medical and Prescription Drug Plan

[ ] I waive health coverage for myself [ ] I waive health coverage for my spouse/Dom. Ptnr. [ ] I waive health coverage for my children

DENTAL INSURANCE ENROLLMENT

Coverage Selection: [ ] Employee only [ ] Employee + Spouse/Domestic Partner [ ] Employee + Child(ren) [ ] Family

[ ] Delta Dental Plus Plan
[ ] Delta Dental Basic Plan

[ ] I waive dental coverage for myself [ ] I waive dental coverage for my spouse/Dom. Ptnr. [ ] I waive dental coverage for my children

VISION INSURANCE ENROLLMENT

Coverage Selection: [ ] Employee only [ ] Employee + Spouse/Domestic Partner [ ] Employee + Child(ren) [ ] Family

[ ] I waive vision coverage for myself [ ] I waive vision coverage for my spouse/Dom. Ptnr [ ] I waive vision coverage for my children

FLEXIBILE SPENDING ACCOUNT ENROLLMENT

Health Flexible Spending Account
I hereby elect to reduce compensation, for the HFSA, by $_____per each pay period which is a total of $_____ for the rest of the plan year. The maximum contribution is $2,500.

[ ] I hereby elect not to participate in the HFSA.

Dependent Care Flexible Spending Account
I hereby elect to reduce compensation, for dependent care expenses, by $_____per each pay period which is a total of $_____ for the rest of the plan year. The maximum contribution is $5,000 per household per calendar year.

[ ] I hereby elect not to participate in the DCFSA.

FUTURE CHANGES TO BENEFIT ENROLLMENTS

The elections you make now may not be changed until the next open enrollment period for Cheyenne Regional Medical Center. If you decide to waive coverage for yourself or dependents, you may not change until the next open enrollment or if one of several qualifying events occur, such as marriage, birth, or change in spouse's employment. Any qualified mid-year change must be requested within 2 days of the qualifying event and must be evidenced with supporting documentation. By signing below I authorize payroll deductions for the employee portion(s) of the premium(s) for the coverage(s) that I have elected above.

AUTHORIZATION

I HEREBY (1) request the coverage for which I am or may become eligible under the group policy or policies issued by Cheyenne Regional – BestLife Medical and Prescription Drug Plan; (2) certify that the above dates of birth are correct: (3) agree that any misstatement or failure to report information may be used as the basis for rescission of coverage for me and my dependents (4) represent that my answers to the foregoing questions and any statements made on this application are true and complete and (5) understand that among the requirements for continued eligibility is that I be a full or part-time, active employee working the number of hours designated by Cheyenne Regional to be classified full or part-time. I authorize any physician, medical professional, hospital, clinic, other medically related facility, insurance or re-insurance company, the Medical Information Bureau, Inc. consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my enrolled spouse and/or children and other non medical information about me or my enrolled spouse and/or children, to give to Wyoming Health Solutions or all of the above sources except the MIB, any and all such information. I understand the information obtained by use of this Authorization will be used by Wyoming Health Solutions to determine eligibility for insurance. Any information obtained will not be released by Wyoming Health Solutions to any person or organization EXCEPT to reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize. I know that I may request a copy of this Authorization. I agree this Authorization shall be valid for 24 months from the date shown below.

Employee's Signature:_____ Date:_____