Forms Kit

March 2014– February 2015

Open Enrollment Instructions 2014

The open enrollment period for the March 1, 2014 to February 28, 2015 plan year is occurring now! During this period, employees can elect new coverage, terminate and/or change their current coverage options. Changes made during the open enrollment period will be effective March 1, 2014. Changes made outside this period are only allowed due to a qualifying life changing event such as marriage, divorce, the birth or adoption of a child, and loss of other health coverage. Forms must be submitted within 30 days of a qualifying event. The forms below are required for the benefits plan year of 2014, which begins on March 1. **All employees must complete the Payroll Deduction Authorization form for this year by 02/24.**

1. To facilitate the open enrollment we will be using ADP. Once you log onto ADP, click on the benefits tab and then click on review change benefits. The wizard will then walk you through your benefit selections.

2. Because this is the first year using the ADP system, please complete the **2014 Employee Benefits Payroll Deduction Authorization Form:** EVERY EMPLOYEE MUST complete this page. If you choose not to elect a line of coverage, please circle "Waive". For ease, you can either email the form to benefits@foxholetechnology.com or fax it to 703-877-0266.

3. Anthem Medical: The attached forms should be used to enroll in Medical coverage for the POS and PPO plans.

   - If you have **no changes** to make to your current plan, you **do not** need to complete the Employee Health Enrollment application.
   - If you are electing Medical coverage for the first time you must complete the Employee Health Enrollment application.
   - If you are making any plan changes (switching plans, enrolling dependents, etc.) You must complete the Anthem Member Change Form.

4. **Discovery Benefits Flexible Spending Account**: Foxhole Technology offers 3 types of flexible Spending accounts:

   - Medical FSA
   - Dependent Care
   - Qualified Transportation Plan

   The ADP benefits wizard will walk you through these benefits selections. If you chose not to elect, please Decline this coverage.

If you have any questions please do not hesitate to call (301) 921-7804 or contact:

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Alexis Tucker – AlexisT@iben.com
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2014 Employee Benefits Payroll Deduction Authorization

EMPLOYEE INFORMATION
EMPLOYEE NAME:
I elect the following benefits and designate the following amount for each benefit I have selected for the March 1, 2014 through February 8, 2015 Plan Year. Foxhole and I agree that my pay will be reduced by the amounts set forth below for each pay period (24) and plan year.

Medical Coverage - Anthem		
	POS	**PPO**
Employee Only	☐ $33.99	☐ $63.45
Employee & Spouse	☐ $85.68	☐ $155.45
Employee & Child	☐ $52.25	☐ $94.80
Employee & Children	☐ $77.76	☐ $141.08
Employee & Family	☐ $117.99	☐ $214.09
	☐ Waive	

IS THIS A CHANGE IN COVERAGE FROM LAST YEAR? ☐ Yes ☐ No

Waiver of Participation: I certify that I am covered for health benefits under another plan, and therefore waive my right to be covered under the group health plans offered by iBEN. I understand that if I wish to participate at a later date, I may be required to furnish a HIPAA certificate of prior coverage as a condition for coverage or I may have a waiting period for any pre-existing conditions.

My coverage is provided through (Carrier Name): ____

FLEXIBLE SPENDING ACCOUNTS -- CARRIER

	Salary Reduction Per Pay	Number of Pay Periods	Annual Election
☐ Dependent Care FSA	_____________._______	X 24	= _____________._______
(Maximum of $5,000 per household) Benefit available for families with both parents working or attending school			
☐ Medical Expense FSA	_____________._______	X 24	= _____________._______
(Maximum of $2,500)			
☐ Parking FSA	_____________._______	X 24	= ____________._______
(Parking – Monthly Maximum Pre-tax $250)			
☐ Transit FSA	_____________._______	X 24	= ____________._______
(Transit – Monthly Maximum Pre-tax $130)			

☐ I waive participation in the Flexible Spending Account

ALL BENEFITS

I understand and agree that the deductions I have requested above will be deducted from my paychecks pre-tax in accordance with the company's Section 125 Plans.

☐ YES ☐ NO

2014 REQUIRED FEDERAL NOTICES

☐ Children's Health Insurance Program (CHIP)
☐ General Notice of Pre-Existing Condition Exclusion
Patient Protection and Affordable Care Act Notices
☐ Designation of Primary Care Providers
☐ Coverage for Obstetric or Gynecological Care
☐ Prohibition on Rescissions
☐ Summary of Benefits and Coverage
☐ Grandfather Status Disclosure
☐ Medicare Part D
☐ Special Enrollment Notice
☐ Women's Health and Cancer Rights Act
☐ Newborn Mother's Health Protection Act

Please sign your full name: ___________________________________

Please print your full name: ___________________________________ Date: _________________

EMPLOYEE HEALTH ENROLLMENT APPLICATION

(Group Size 15+)

Please PRINT in ink and return to your employer. Use extra sheets of paper if necessary. The Primary Care Physician (PCP) listings of Anthem and its affiliated POS company can be obtained through www.anthem.com.

APP

EMPLOYER/GROUP USE ONLY

Group Name			Group Number	Effective Date M D Y
Date of hire	Full time hire date	# Hours working per week	Date of eligibility for coverage	
Position/Title			Employee's Social Security #:	

1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

❏ **Anthem Blue Cross and Blue Shield** (PPO) ____________________

❏ **HealthKeepers, Inc.** ____________________ **(POS)**

Note for Lumenos Health Savings Account (HSA) enrollees:
If you enroll in an Anthem Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Coverage Option
If your employer/group offers POS coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

2. REASON FOR APPLICATION (Check as many as apply)

❏ Initial enrollment
❏ Annual open enrollment
❏ New hire
❏ Rehire – Date of rehire: ____
❏ COBRA – Qualifying Event: ____
Event Date: ____

❏ Marriage
Date of marriage: ____
❏ Loss of eligibility for other coverage
Date previous coverage ended: ____
❏ Birth of child
❏ Add Dependent*
Date of adoption/placement for adoption, court order or legal appointment: ____

*If adding a dependent due to adoption, placement for adoption, medical child support order, legal appointment (such as guardianship), legal documentation must be attached to the enrollment application.

3. TYPE OF COVERAGE/PLAN

Health Coverage
❏ Employee Only
❏ Employee and Spouse
❏ Employee and One Child
❏ Employee and Children
❏ Employee and Family

Vision Coverage
❏ Voluntary Vision
(type of coverage must match health coverage)

4. EMPLOYEE INFORMATION* (Please refer to Definitions of Eligibility, Section 9)

**If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name, PCP number and address.*

Social security # – –	Date of birth (MM/DD/YYYY)	Sex: ❏ M ❏ F
Last name	First name	M.I.
Street address (Please include Apt. #)		
City	State	Zip
Daytime phone (with area code) ( ) –	Evening phone (with area code) ( ) –	
Email address		
Anthem PCP name* (please provide first and last name)	Anthem PCP ID number*	
PCP Address	Current patient? ❏Yes ❏No	

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IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3

5. FAMILY INFORMATION* (If electing Employee Only coverage, skip to Section 6)

**If applying for HMO or POS coverage, list the PCP name and PCP number. Each family member may select a different PCP.*

List all family members applying for coverage. List additional dependents on a separate sheet and attach it to the application. Please indicate the relationship between you and each dependent and provide the social security number and date of birth for each covered dependent. In the event of adding a newborn for which their social security number is not available, please complete this application at this time and forward to Anthem their social security number when obtained.

Relationship to applicant	Social security #	Date of birth (MM/DD/YYYY)	Sex:
❑Spouse ❑Domestic Partner	– –		❑M ❑F

Last name	First name	M.I.

Anthem PCP Name*	Anthem PCP ID #*

Email address

Anthem PCP Address	Current patient? ❑Yes ❑No

Relationship to applicant	Social security #	Date of birth (MM/DD/YYYY)	Sex:
❑Child	– –		❑M ❑F

Last name	First name	M.I.

Check all that apply:

- ❑ Child is covered by non-custodial parent due to medical child support order (attach documentation)
- ❑ Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*

Email address (optional – dependent must be age 18 or older)

Anthem PCP Address	Current patient? ❑Yes ❑No

Relationship to applicant	Social security #	Date of birth (MM/DD/YYYY)	Sex:
❑Child	– –		❑M ❑F

Last name	First name	M.I.

Check all that apply:

- ❑ Child is covered by non-custodial parent due to medical child support order (attach documentation)
- ❑ Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*

Email address (optional – dependent must be age 18 or older)

Anthem PCP Address	Current patient? ❑Yes ❑No

IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3

Relationship to applicant ❑Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: ❑M ❑F
Last name	First name		M.I.

Check all that apply:
- ❑ Child is covered by non-custodial parent due to medical child support order (attach documentation)
- ❑ Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*
Email address (optional – dependent must be age 18 or older)	
Anthem PCP Address	Current patient? ❑Yes ❑No

Relationship to applicant ❑Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: ❑M ❑F
Last name	First name		M.I.

Check all that apply:
- ❑ Child is covered by non-custodial parent due to medical child support order (attach documentation)
- ❑ Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*
Email address (optional – dependent must be age 18 or older)	
Anthem PCP Address	Current patient? ❑Yes ❑No

6. TELL US ABOUT YOUR OTHER INSURANCE

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name	Policy/ID number

Effective date (MM/DD/YY)	Please indicate whom this coverage applies to (check all that apply): ❑Self ❑Spouse ❑All Children ❑Child: ______ Last Name First Name

Do you intend to continue this coverage? ❑Yes ❑No

If no, please provide cancellation date of coverage: ______

If yes, please provide the following information:

Address of other coverage		
City	State	Zip

Phone number of other carrier/plan ( ) –	Policyholder name (Last, First, M.I.)
Policyholder's date of birth	Type of coverage: ❑Health ❑Dental ❑Group Insurance ❑Non Group Insurance

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A, B & D complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person			First name	M.I.
HIC #	Medicare Part A Effective date	Medicare Part B Effective date	Medicare Part D Effective date	65 or over: ❑Working ❑Retired

Reason for Medicare Entitlement:

❑Age ❑Disability ❑End Stage Renal Disease (ESRD) ❑ESRD & Disability

8. DEFINITIONS

Eligible employee:

- An active employee of the Group Policyholder who works the number of hours per week to be eligible for benefits as defined by the employer and approved by Anthem as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Group Policyholder, provided that written approval of their eligibility is obtained from the HMO or Anthem Blue Cross and Blue Shield; or
- Employees eligible for continuous coverage under state or federal laws, e.g. COBRA.
- To become an eligible employee, a director or officer of a corporate Group must meet the same requirements as other employees of the Group Policyholder.
- Independent contractors (those whose wages are reported on IRS Form 1099) are considered to be self-employed and are not eligible for group coverage.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under State or Federal laws, e.g. COBRA.

9. EMPLOYEE CERTIFICATION (Please date and sign this certification.)

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under the policy.

- For Lumenos Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.
- If the Company checked on page 1 of this application is Anthem Blue Cross and Blue Shield (Anthem), I understand that if false or misleading information is discovered within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.
- If the Company checked on page one of this application is HealthKeepers, Inc., I understand that the health maintenance organization (HMO) may cancel my coverage with 31 days advance written notice of termination if it finds, within two years of the effective date of my coverage, that I misrepresented information on this application.

The employee, and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature ______________________________ Date ______________

Member Change Form

Instructions: Please complete in ink and return to your employer. Use extra sheets of paper if necessary. Anthem's Primary Care Physician (PCP) listings can be obtained through www.anthem.com.
IF ADDING AN ELIGIBLE DEPENDENT PLEASE COMPLETE ENROLLMENT APPLICATION.

MCF

GROUP INFORMATION – This section should be completed by Group Administrator (if applicable)

❑ **HealthKeepers, Inc. (POS)** ❑ **Priority Health Care, Inc. (HMO)**
❑ **Peninsula Health Care, Inc. (HMO)** ❑ **Anthem Blue Cross and Blue Shield (Par/PPO)**

Effective date of change (subject to plan guidelines)
Mo Day Year

Group Name | Group Number

MEMBER INFORMATION (please print or type)

Member identification number (Please provide information as shown on your ID card):

Last name | First name | M.I.

❑ ***Personal Data Change***
(Please check the appropriate boxes and complete only those items requesting to be changed as of the effective date noted above. For social security number, attach appropriate documentation.)

❑ **Name Change** (employee only)
❑ **Name Correction** (employee & dependent)
❑ **Social Security Number Correction**
❑ **Address Change**
❑ **Phone Number Change**

New name - Last name | First Name | M.I.

New address - Street | Apt. #

City | State | Zip

New daytime phone (with area code) ( ) | New evening phone (with area code) ( )

Correction of social security number

❑ ***Change in Type of Membership***
❑ **Remove all dependent(s)**
❑ **Remove spouse**
❑ **Remove child** (please provide child's last and first name): ____________________

❑ ***Primary Care Physician (PCP) Change***

Member's first name	Current physician	New physician	Current patient?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

❑ ***Cancellation of Coverage*** ❑ Left organization ❑ Divorced ❑ Moved out of service area ❑ Deceased

Authorization

I authorize the changes, as shown above, to be made by the requested effective date. I authorize my employer to make changes in payroll deductions if required by the health coverage changes I have made. I understand that these changes are effective only after they are accepted by my employer and received by the health care company.

Member signature | Date | Home Telephone

Employer or Group Administrator signature (if applicable) | Date | Telephone

For use by current members only. This is not an application. A new employee must complete an enrollment application.

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