HIGHLINE MEDICAL CENTER

2012 BENEFITS ENROLLMENT FORM

D TO BE COMPLETED BY EMPLOYER (A REASON MUST BE CHECKED FOR ADDING, CHANGING OR TERMINATING COVERAGE):

ADDING: ❑ New Employee Employee Class: All Regular Employees working 48 hours or more per pay period Date of Hire: _____	# Hours Worked per Week: _____ Date of Re-Hire: _____ Date Changed from P/T to F/T: _____	**Life/AD&D/LTD**: Annual Basic Earnings: _____ Occupation: _____	**TERMINATION OF BENEFITS**: ❑ Employee ❑ Dependent Benefit Termination Date: _____ Reason: _____ TE – Termination RH – Reduction in Hours DV – Divorced DE – Death OD – Over age dependent Date notified _____ b y employee/manager
ZENITH REPORTING CODES ❑ 1100 ❑ 1101 **Required:** ❑ SEIU/Non-Contract ❑ IUOE/UFCW	**ADDING DEPENDENT DUE TO**: ❑ Birth ❑ Marriage ❑ Adoption ❑ Loss of Coverage Date of Above Event: _____	**MISCELLANEOUS CHANGES:** ❑ Name Change ❑ Address Change ❑ Open Enrollment Change ❑ PCP Change	
COMPLETE FOR ALL CHANGES: Intended Effective Date: _____ Signature of Employer: _____ Signature Date: _____			

1. EMPLOYEE INFORMATION

Name	Social Security #	Employee ID #	Date of Birth
Street Address	City	State	Zip
Phone #	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Email Address

2. MEDICAL ELECTION

Zenith Administrators, Inc.

201 Queen Ave. N, Ste. 100

Seattle, WA 98109-4896

Monthly Payroll Deduction	**SEIU/Non-Contract Employees**				**IUOE & UFCW Employees**	
Please check mark your medical plan election >>>>	❑ **Highline Only Plan**		❑ **First Choice Plan**		❑ **First Choice Network**	
Please CHECK the box that indicates who you wish to cover on the **Medical** plan.	Full Time Employee (.9-1.0)	Part-Time Employee (.6 - .8)	Full Time Employee (.9-1.0)	Part-Time Employee (.6 - .8)	Full Time Employee (.9-1.0)	Part-Time Employee (.6 - .8)
❑ Employee Only	$0.00	$0.00	$60.00	$60.00	$0.00	$0.00
❑ Employee & Spouse/DP*	$0.00	$254.42	$183.00	$300.30	$0.00	$260.36
❑ Employee & Child	$0.00	$94.61	$95.00	$149.37	$0.00	$96.82
❑ Employee & Children	$0.00	$158.74	$120.00	$209.94	$0.00	$162.45
❑ Employee & Spouse/DP* & Child	$0.00	$349.04	$218.00	$389.66	$0.00	$357.18
❑ Employee & Spouse/DP* & Children	$0.00	$413.17	$243.00	$450.24	$0.00	$422.81

❑ I waive Medical Coverage

❑ I waive Dental Coverage

If you are declining coverage due to your coverage under another group health plan or government sponsored plan, please indicate that you waive your participation in the Plan.

*The premium portion paid by Highline for Domestic Partner (DP) coverage will be added to the employee's gross wages as taxable income in accordance with IRS regulations.

3. DENTAL PLAN ELECTION

Washington Dental Service #0654

9706 4th Ave. NE

Seattle, WA 98115

Monthly Payroll Deduction	
Please CHECK the box that indicates who you wish to cover on the **Dental** plan.	Full/Part-Time Employee
❑ Employee Only	$0.00
❑ Employee & Spouse/DP*	$49.32
❑ Employee & Child	$49.32
❑ Employee & Children	$93.32
❑ Employee & Spouse/DP* & Child	$93.32
❑ Employee & Spouse/DP* & Children	$93.32

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Please provide selected Medical Primary Care Provider Name (REQUIRED):

4. ENROLLMENT INFORMATION FOR SPOUSE/DP AND/OR CHILD(REN)
(IF YOU'RE ENROLLING A SPOUSE/DP OR CHILD TO A PLAN, PLEASE PROVIDE THEIR ENROLLMENT INFORMATION BELOW)

Check "box" to indicate coverage	Medical	Dental	IRS Tax Dependent	Last Name	First Name	M.I.	Social Security #	Date of Birth	Gender (M/F)	If Medical, please Indicate Primary Care Provider Name:
❑ Spouse	❑	❑	❑ YES ❑ NO							
❑ DP	❑	❑	❑ YES ❑ NO							
❑ Child	❑	❑	❑ YES ❑ NO							
❑ Child	❑	❑	❑ YES ❑ NO							
❑ Child	❑	❑	❑ YES ❑ NO							
❑ Child	❑	❑	❑ YES ❑ NO							

REQUIRED AFFIDAVIT SIGNATURE FORM

Sign and date this form below. Documentation is not valid unless this page is **SIGNED** AND **DATED.**

By my signature on this Affidavit and on the Enrollment Form, I certify and warrant that all information, including that of dependents listed as **eligible** dependent(s) on this enrollment document is true, correct and current as of the date signed. I further authorize Highline Medical Center to verify this information at anytime.

Employee Signature **Date**

5. PRIOR OR OTHER GROUP COVERAGE INFORMATION

Do you or any of your dependents applying for coverage have Group **Medical** coverage now, or within the past 3 months? ❑ Yes ❑ No Medicare? ❑ Yes ❑ No
If yes, please provide the following for Group Health to credit any waiting periods (must be completed):

Insurance Company Name | Subscriber Name | Group/ID # | Effective Date | Termination Date

Do you or any of your dependents applying for coverage have other Group **Dental** Coverage? ❑ Yes ❑ No If yes, please provide the following information:

Insurance Company Name | Subscriber Name | Group/ID # | Effective Date | Termination Date

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6. FLEXIBLE SPENDING ACCOUNT – ZENITH ADMINISTRATORS, INC.

I understand that the rules of IRC Section 125 allow me to use part of my salary on a pre-tax basis to purchase one or more of the following qualified benefits. I hereby elect to participate in my employer's Section 125 Flexible Benefits Plan as indicated below.

Premium Conversion	The group medical and/or dental insurance premium you pay through your paycheck is deducted pre-tax, unless informed otherwise.			
Benefit	**Yes/No**	**Annual Election**	**No. of Paychecks**	**Paycheck Deduction**
Health Care FSA Maximum of $2,500.00 per plan year	❑ Yes ❑ No	$_____ per plan year (January 1 – December 31)	**24**	$_____ per paycheck
Dependent Care FSA Maximum of $5,000.00 per plan year ($2,500 if married, filing separately)	❑ Yes ❑ No	$_____ per plan year (January 1 – December 31)	**24**	$_____ per paycheck

List Tax Dependents Eligible For Benefits: _____

7. LIFE/AD&D (EMPLOYER PAID PLANS) – UNUM LIFE INSURANCE COMPANY

Highline provides Life/AD&D insurance to all regular employees who work more than 48 hours per pay period in the amount of **$10,000.**

BENEFICIARY DESIGNATION (Please complete the information below to designate a Beneficiary, in the event of a Life Insurance claim):

Primary Beneficiary Designation (Full Name)	**Social Security # (if known)**	**Relationship to Employee (you)**	**% Share of Proceeds to Beneficiary (must equal 100%)**
Secondary Beneficiary Designation (Full Name)	**Social Security # (if known)**	**Relationship to Employee (you)**	**% Share of Proceeds to Beneficiary (must equal 100%)**

8. OPTIONAL (EMPLOYEE PAID) LIFE FOR EMPLOYEES AND DEPENDENTS – UNUM LIFE INSURANCE COMPANY POLICY

Employees and dependents can also apply for additional Life insurance coverage, at a minimal cost. Additional Life Insurance amounts range from $10,000 to $500,000; if you apply for an amount greater than $200,000, an **Evidence of Insurability Form must be completed**. Please see plan summary for further information on Employee and Dependent coverage options and cost. Indicate your Optional Life election below:

❑ Yes - **Please complete separate enrollment form for Optional Life**

❑ No

9. LONG TERM DISABILITY (LTD) COVERAGE CORE & BUY-UP OPTION – UNUM LIFE INSURANCE COMPANY POLICY

Highline provides a Core Long Term Disability (LTD) plan at no cost to you. The LTD plan provides you with a benefit of 40% of your monthly salary up to monthly maximum of $1,000, in the event of a disability. You have the opportunity to purchase additional LTD coverage, at a minimal cost. The buy-up LTD plan provides you with a benefit of 60% of your monthly salary up to monthly maximum of $5,000, in the event of a disability. Please see plan summary for coverage details and cost. Indicate your LTD election below:

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❑ Yes, I would like to enroll in the buy-up LTD plan - **Please see below for monthly cost calculation**

To calculate the cost for the Buy-up option:

Monthly Salary (Max $2,500)_____ x .140/100 =_____ (A)

Monthly Salary (Max $8,333) _____ x .790/100 = _____ (B)

(B) _____ - (minus) (A) _____ = Your Monthly Cost

Example: Your base monthly salary is $4,000 per month
$2,500 x .140/100 = $3.50 = A
$4,000 x .790/100 = $31.60 = B
(B) $31.60 - (A) $3.50 = $28.10 per month is your cost.

❑ No, I decline to enroll in the buy-up LTD plan. **I will be automatically enrolled in the Core plan.** I understand that if I choose to enroll in the Buy-up plan at a later date, I will be subject to a pre-existing limitation at that time.

10. Your special enrollment period rights for individuals who are eligible for enrollment in a group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that coverage (or if, in the case of group health plan coverage the employer stops contributing toward you or your dependents' coverage.) However, you must request enrollment 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward you or your dependents' coverage.) In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment 31 days after the marriage, or within 60 days of birth, adoption, placement for adoption or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. To request special enrollment or obtain more information, please contact your group administrator or benefits department.

11. EMPLOYEE RELEASE AND AUTHORIZATION: I hereby apply for the benefit plans for which I am eligible. I authorize payroll deductions if applicable. I understand that subject to Federal and State income tax laws, the deductions will be made before taxes. I understand that I cannot change the medical elections or add dependent medical coverage during the plan year unless I have a qualifying event. I also certify that the dependents listed are eligible for dependent Health and Dental coverage as detailed in the plan document. I understand that any section above that is left blank will be considered a voluntary waive of coverage and that I will have to wait until the next enrollment period to enroll. In accordance with RCW 48.135.080, I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. The insurance carrier is responsible for confidential data. State and Federal law assures that private health information will be held confidential.
I understand that my employer has a legitimate need to know the federal income tax status of my dependent relationship. I understand, that based on my election above, that premium contributions for any non-IRS tax dependent enrolled cannot be taken on a pre-tax basis and the value of the benefits my employer provides for my non-IRS tax dependent will be added to my taxable income and the appropriate taxes will be withheld from my pay. This declaration of tax status may have legal implications under federal and/or state law.
This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for "qualifying medical care expenses" for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for "qualifying dependent care expenses." I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown for the plan year indicated on the previous page.

EMPLOYEE SIGNATURE:	**DATE:**

ENROLLMENT FORMS TO BE RETURNED TO:
Human Resources/Benefit Specialist
Highline Medical Center/Specialty Campus
12844 Military Rd. S.
Tukwila, WA 98168
Phone: 206-248-4610