Benefits Enrollment & Change Form

Check all coverage that applies: ☐ Medical ☐ Dental ☐ Vision ☐ Life

Reason(s) for Completing Application:

☐ New Hire Enrollment
☐ Reinstate Coverage
☐ Cancel Coverage
☐ Coverage Change
☐ Information Change
☐ Add Dependent(s)
☐ Drop Dependents
☐ Open Enrollment

Effective Date: _____ Date of Hire: _____ Home Phone: _____

Name and Current Address:

Name:

Address:

City: State: Zip:

Hours worked per week_____ Marital Status ☐ Married ☐ Single ☐ Divorced

Section I: Employee and Dependent Information

Last Name	First Name	M.I.	Gender	Birth Date	Social Security #	Relationship
						Self
						Spouse
						Child
						Child
						Child
						Child

SECTION II: Benefits & Coverage Desired (Monthly Employee Contributions are listed)

Medical Coverage: UnitedHealthcare

Plan One
☐ $94.54 Employee Only
☐ $215.58 Employee/Spouse
☐ $193.60 Employee/Child(ren)
☐ $358.75 Family

Plan Two
☐ $45.73 Employee Only
☐ $117.95 Employee/Spouse
☐ $100.86 Employee/Child(ren)
☐ $212.31 Family

☐ Waive Medical Coverage

Dental Coverage: MetLife

☐ $20.59 Employee Only
☐ $43.13 Employee/Spouse
☐ $53.28 Employee/Child(ren)
☐ $70.76 Family
☐ Waive Dental Coverage

NOTE: MetLife may waive late entrant penalties if coverage is elected within 31 days of a qualifying event. Qualifying events include, but are not limited too, loss of coverage, marriage, divorce, birth or adoption of a child, death or court order.

Vision Coverage: EyeMed

☐ $5.58 Employee Only
☐ $10.59 Employee/Spouse
☐ $11.15 Employee/Child(ren)
☐ $16.39 Family
☐ Waive Vision Coverage

If you waive the vision coverage, and elect coverage at a later date, enrollment delays may apply.

Life Coverage Underwritten by Relia Star Life Insurance Company

☐ Employee Only $10,000
☐ Spouse $2,000
☐ Child(ren) $1,000

This coverage is 100% paid by Navajo Express, however in the unlikely event you decide to waive coverage you will have to provide proof of each person's insurability. Relia Star Life Insurance Company has the right to reject your request.

Employee Life Insurance:

Primary Beneficiary(ies)	Relationship to employee/SSN	Percentage
_____	_____	_____
_____	_____	_____

Contingent Beneficiary(ies)	Relationship to employee/SSN	Percentage
_____	_____	_____
_____	_____	_____

NOTE: The employee is the beneficiary for any dependent spouse/ child(ren) coverage.

SECTION III: Deductions

Please indicate either pre-tax or post-tax deduction of employee contributions:

☐ I understand that the employee contributions will be deducted from my compensation on a **pre-tax** basis.

☐ I waive pre-tax deduction of employee contributions. I understand that the employee contributions will be deducted from my compensation on a **post-tax** basis.

_____Initial

SECTION IV: Medicare or Other Health Insurance Coverage

Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied for coverage?

☐ YES ☐ NO If yes, please complete the section below:

Member Name	Type of Coverage	Carrier Name	Start	End

SECTION V: Dependent Eligibility

By initialing below, I verify and attest that the dependent(s) named above are eligible for coverage as defined by the plan document(s). For said dependent(s), you may be required to furnish satisfactory evidence that 1) verifies the dependent relationship (for example marriage certificate or record of birth); or 2) the dependent relies on me due to mental and/or physical disability. **I understand that I am responsible for notifying the Plan within 31 days of any changes to the status of my dependent(s).** I understand that the plan reserves the right to request, at any time, proof of coverage dependency.

_____Initial

SECTION VI: Waiver of Coverage

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan. The plan has been explained to me, and I decline to participate for the following reason:

☐ I have other group health insurance ☐ I have other individual health coverage ☐ I am eligible for veteran or military benefits

SECTION VII: Signature

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between the Plan and me. I also understand that it is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides incomplete or misleading facts to a policyholder or claimant for the purpose of defraud or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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Signature of Employee Date