Caring Home Health

MultiPlan/PHCS Third Party Medical Plan

Effective 10/01/2018

Payroll Deduction Form

Employee Name:_____ Date of Birth:_____

Social Security #:_____ Gender (M/F)_____ Phone#:_____

Mailing Address:_____

Email Address:_____ Avg. Hours Worked/Week:_____

Dependent Information:

Last Name	First Name	MI	Social Security #	Date of Birth	Gender (M/F)	Relationship to Employee

Please initial next to the plan option you are selecting for this Health Insurance Plan Year:

Plan Bronze 402 MVP	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$553.30	$438.30	$115.00	$57.50	_____
Employee+Spouse	$968.06	$438.30	$529.76	$264.88	_____
Employee+Child(ren)	$737.18	$438.30	$298.88	$149.44	_____
Employee+Family	$1,151.95	$438.30	$713.65	$356.83	_____

Plan Bronze 401	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$573.44	$438.30	$135.14	$67.57	_____
Employee+Spouse	$1009.16	$438.30	$570.86	$285.43	_____
Employee+Child(ren)	$766.61	$438.30	$328.31	$164.16	_____
Employee+Family	$1,202.33	$438.30	$764.03	$382.02	_____

Plan Bronze 400	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$601.64	$438.30	$163.34	$81.67	_____
Employee+Spouse	$1,066.69	$438.30	$628.39	$314.20	_____
Employee+Child(ren)	$807.81	$438.30	$369.51	$184.76	_____
Employee+Family	$1,272.85	$438.30	$834.55	$417.28	_____

OVER-

Caring Home Health

Plan DENTAL PPO	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$37.08	$0	$37.08	$18.54	
Employee+Spouse	$71.69	$0	$71.69	$35.85	
Employee+Child(ren)	$92.63	$0	$92.63	$46.32	
Employee+Family	$127.25	$0	$127.25	$63.63	

Plan DENTAL HMO	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$13.74	$0	$13.74	$6.87	
Employee+Spouse	$22.93	$0	$22.93	$11.47	
Employee+Child(ren)	$30.47	$0	$30.47	$15.24	
Employee+Family	$40.75	$0	$40.75	$20.38	

Plan VISION	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$8.79	$0	$8.79	$4.40	
Employee+Spouse	$17.58	$0	$17.58	$8.79	
Employee+Child(ren)	$19.34	$0	$19.34	$9.67	
Employee+Family	$28.12	$0	$28.12	$14.06	

Plan Life & AD&D	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Coverage Amount					
Primary Beneficiary	%			Relationship	
Contingent	%			Relationship	

Declination of Coverage: I hereby waive coverage for (Check All That Apply)

Medical	Myself ☐	My Spouse ☐	My dependent	children ☐	
Dental	Myself ☐	My Spouse ☐	My dependent	children ☐	
Vision	Myself ☐	My Spouse ☐	My dependent	children ☐	
I decline to apply for group coverage because of: Spousal Coverage ☐		*Medicare Supplement* ☐		*Individual Coverage* ☐	

Other Coverage ☐

By signing below I understand that the employee cost of the above elections will be deducted from each paycheck starting the month that coverage will be effective. I acknowledge that the coverage available to me has been explained to me and I knowingly have elected to enroll in this coverage. I understand, agree and represent that I have read this document or it has been read to me and that the answers provided within this entire document are to the best of my knowledge and belief, and are true and complete. I understand that if any intentional material false statement, misrepresentation or omission is contained here my coverage could be reduced, denied or voided. I further authorize my employer to deduct from my earnings the contributions (if any) elected above I acknowledge that at any time I may be required to complete additional applications at the request of the insurance carrier.

Employee Signature _____ **Date** _____

Before beginning, please ensure you have the names of your medications and dosage information immediately available.

Medical Application

Employer:_____

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	HOME/ CELL PHONE ( )

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

MARRIED ☐ YES ☐ NO	SEX ☐ M ☐ F	BIRTH DATE	JOB TITLE	DATE EMPLOYED

DATE OF MARRIAGE: Month Day Year

Are you actively at work? ☐ YES ☐ NO Working 30hrs or more per week (avg)? ☐ Yes ☐ No

Are you covering your dependents? ☐ YES ☐ NO

Relation To Employee	Last Name	First Name	Social Security Number	Date of Birth	Sex M/F
Spouse					
Dependent Child					
Dependent Child					
Dependent Child					

Do you or your dependents have other medical coverage? ☐ No ☐ Yes (☐ Self ☐ Spouse ☐ Children)

NAME OF INSURED	SOCIAL SECURITY NUMBER	NAME OF OTHER INSURANCE COMPANY	GROUP NO.

EMPLOYER OF INSURED	EMPLOYER ADDRESS	CITY	STATE	ZIP

To the best of my knowledge, I believe the above information is true and correct. I understand that false or inaccurate information may result in the termination of coverage or the non-payment of benefits.

PLEASE TYPE YOUR NAME HERE _____ Date Signed

Waiver of Insurance Coverage

Rejection of Health Coverage. After careful consideration, I do not wish to participate in any of the available plans. I also realize I will NOT be able to re-enroll until next open enrollment period and then I may be required to provide Medical Proof of Insurability.

PLEASE TYPE YOUR NAME HERE TO WAIVE _____ Date Signed

PERSON	PLEASE CHECK THE BOX FOR EACH FAMILY MEMBER THAT IS CHOOSING MEDICAL COVERWGE:
Employee	☐Yes ☐No
Spouse	☐ Yes☐No
Children	☐ Yes☐No

08.31.2016

HEALTH STATEMENT – Please complete for only those persons electing coverage.

You may be asked to call a medical underwriter to answer questions about any health information you are providing and / or missing on this form. This interview may be recorded for quality assurance.

DAYTIME PHONE NUMBER ( ) -

1. Within the **past 5 years,** have you, your spouse, or dependent children been tested, diagnosed, or treated **(including the use of medication),** been advised to seek treatment, or has any further treatment been recommended for:	
A. Arthritis, Bone, Joint, Spine, Musculoskeletal Disorders, Muscle or Connective Tissue Disorder	☐ Yes ☐ No
B. Bone Marrow or Organ Transplants	☐ Yes ☐ No
C. Cancer, Tumor or Polyp	☐ Yes ☐ No
D. Cirrhosis, Hepatitis or other diseases of the Liver	☐ Yes ☐ No
E. Collagen Disease including Lupus	☐ Yes ☐ No
F. Digestive System Disorder, including Diseases of the Colon, Gallbladder, Pancreas, Stomach, Esophagus or Intestines	☐ Yes ☐ No
G. Diabetes, Thyroid Disorder or Disease of the Endocrine System	☐ Yes ☐ No
H. Drug Abuse, Alcohol Abuse, Fetal Alcohol Syndrome or Psychiatric Disorder	☐ Yes ☐ No
I. Eyes, Ears, Nose, Throat Disorder, or Meningitis	☐ Yes ☐ No
J. Genetic, Growth or Developmental Disorder	☐ Yes ☐ No
K. Heart, Circulatory Disorder, Blood Disorder (including High Blood Pressure) or Edema	☐ Yes ☐ No
L. Immune System Disorder, including AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)	☐ Yes ☐ No
M. Metabolic and Nutritional Disorders (including Hypercholesterolemia)	☐ Yes ☐ No
N. Quadriplegia, Paraplegia, Hemiplegia or Congenital Disorder	☐ Yes ☐ No
O. Neurological Disorder, including Alzheimer's Disease, Brain Disorders, Cerebral Palsy, Epilepsy, Migraines, Parkinson's Disease, Seizures or Multiple Sclerosis	☐ Yes ☐ No
P. Reproductive System Disorder including Infertility Treatment	☐ Yes ☐ No
Q. Respiratory Disorder or Sleep Disorder	☐ Yes ☐ No
R. Rheumatic Fever or Cystic Fibrosis	☐ Yes ☐ No
S. Urologic Disorders or Renal Disorders (including Renal Failure)	☐ Yes ☐ No
T. Vascular Disorders including stroke, CVA (Cerebro Vascular Accident) or TIA (Transient Ischemic Attack)	☐ Yes ☐ No
2. Do you, your spouse, or dependent children have any condition that may require diagnostic testing, medical, surgical, or hospital care, or any condition, illness, or injury for which a physician has not yet been consulted?	☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant or in the process of adopting a child? **(If "Yes", provide the due / adoption date on the next page and describe any complications experienced or if multiple births are expected.)**	☐ Yes ☐ No
4. Are you or any of your dependents currently disabled?	☐ Yes ☐ No
5. Have you or any of your dependents been hospitalized for any treatment or procedure within the past 12 months?	☐ Yes ☐ No

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DETAILS FROM HEALTH STATEMENT ABOVE –

Please fully complete the following information

Question Number & Letter	First Name, Last Name	Diagnosis & Details about Conditions above *(Please list Medications, Dosage and Frequency)*	Date of onset	Date of Full Recovery	Doctors name & phone number

REPRESENTATION & AUTHORIZATION – Please read this section carefully then sign & date the form below

SPECIAL ENROLLMENT NOTICE

If you decline medical and/or dental coverage for yourself, your spouse, or your dependents at this time for any reason, you may later be eligible to enroll yourself, your spouse and/or your newly acquired dependent(s) in medical and/or dental coverage within 30 days of acquiring the dependent(s) through marriage, birth, adoption, or placement for adoption.

If you decline medical and/or dental coverage for yourself or your dependents at this time because of coverage under other health insurance coverage, you or your dependents may later be eligible to apply for medical and/or dental coverage without penalty within 30 days after you or your dependents' other health coverage ends, but only if you state in STEP 4 that other health coverage is the reason for declining coverage. The penalty for failure to state that other health coverage was the reason for declining this coverage will be a 6-month waiting period under this plan after you apply for coverage hereunder.

I represent: (1) I am an employee of the participating employer and the persons for whom I am requesting coverage are US Citizens or Legal Aliens residing in the USA; (2) the statements and answers to the questions on this Enrollment/Refusal Form made by me are true and complete to the best of my knowledge; (3) I understand that the statements and answers to questions on this Enrollment/Refusal Form made by me and any subsequent information I provide are the basis for my coverage under my employer's plan and coverage will not be effective until I am notified of my effective date; (4) if any controversy or claim is made arising out of or relating to a claim for benefits payable by the self-funded plan it shall be settled by arbitration in accordance with the provisions of the plan.

I authorize: (1) any physician, medical practitioner, hospital, clinic, pharmacy benefit managers, Veteran's Administration, or other medical-related facility, insurance agent, administrator, insurance company, reinsurer, consumer reporting agency, telephone interview company, or my employer to release any information pertaining to my employment or to the health of myself or my dependents, including physical or mental disorders or the use of drugs and alcohol (May require a separate authorization), to my employer's Third Party Administrator (TPA); (2) My employer's TPA to release such information to any insurance agent, insurance company, reinsurer, managed care organization, telephone interview company, other insurance support organization; (3) my employer only to deduct contributions from my earnings to be applied to the cost of this plan; and (4) that benefits under this plan be paid directly to any managed care provider utilized by me or my family.

I agree this authorization will be valid for two years from the date this form is signed and that a photocopy of this authorization is as valid as the original for my dependents and myself.

Fraud Notice:

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties.

HAS ANY PERSON ASSISTED YOU IN THE COMPLETION OF THIS FORM? O YES O NO IF YES, PRINT NAME: _____

Employee Signature X _____ **Date Signed:** _____

PLEASE TYPE YOUR NAME HERE