TOTAL PATIENT CARE
HOME HEALTH

FOR COMPANY USE ONLY (EFFECTIVE SEPTEMBER 1, 2017)		
Class: _____	***Per Pay Period Employee Pre-Tax Deductions:***	***Per Pay Period Employee Post-Tax Deductions:***
Salary: _____	Medical: $ _____	Supplemental Life: $ _____
Location: _____	Dental: $ _____	Dependent Life: $ _____
Occupation: _____	Basic Life/AD&D $ Employer Paid	Voluntary STD: $ _____
New Hire Date: _____	Vision: $ _____	Voluntary LTD: $ _____
Effective Date: _____	HSA Contribution: $ _____	

ENROLLMENT INFORMATION

REASON FOR ENROLLMENT: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event ☐ Late Entrant

COVERAGE SELECTED: ☐ Medical ☐ Dental ☐ Vision ☐ Voluntary Life ☐ STD ☐ LTD

STATUS CHANGE: ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination
☐ Electing COBRA (Reason for Election) _____
☐ Waiver of Coverage ☐ PCP Selection/Change ☐ Other _____

PERSONAL INFORMATION

Employee's Full Name		**SSN**		**Occupation**	
Home Address		**City**	**State**	**Zip Code**	**County**
Home Phone	**Work Phone**	**Email Address**		**Date of Birth**	**Date of Hire**
Gender ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married	**Primary Language** ☐ English ☐ Spanish ☐ Other _____		**Hours Worked Per Week**	

DEPENDENTS TO BE COVERED

Name of Person to be Covered Last First MI	**SSN**	**Gender**	**Date of Birth**
Spouse		☐ M ☐ F	
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child * Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child * Resides with Employee ☐ Yes ☐ No			

OTHER HEALTH INSURANCE INFORMATION

Are you presently covered on a health insurance plan? ☐ Yes ☐ No **If yes,** how long has this coverage been continuous? _____

If yes, what type of coverage: ☐ Spouse's Coverage ☐ COBRA ☐ Present Employer's Coverage ☐ Medicare/Medicaid ☐ Other _____

Name of Present Insurance Company: _____ Name of Policy Holder: _____

Policy # or Medicare #: _____ Address of Insurance Company: _____

After coverage becomes effective with (Employer) are you or any family members to be covered by another medical insurance or Medicare?

☐ Yes ☐ No

MEDICAL PLAN (Choose One) Rates are based on 26 pay period deductions after ER contr.

☐ Waive Coverage	☐ S609CHC HSA	☐ S608CHC PPO	☐ S608ADT HMO	☐G653ADT HSA-HMO
☐ Employee Only	$134.92	$184.55	$58.77	$40.63
☐ Employee & Spouse	$436.00	$535.24	$283.69	$247.41
☐ Employee & Child(ren)	$436.00	$535.24	$283.69	$247.41
☐ Employee & Family	$737.07	$885.94	$508.61	$454.21

DENTAL PLAN - Rates are based on 26 pay period deductions

☐ Waive Coverage	
☐ Employee Only	$21.08
☐ Employee & Spouse	$42.37
☐ Employee & Child(ren)	$39.62
☐ Employee & Family	$67.34

VISION PLAN - Rates are based on 26 pay period deductions

☐ Waive Coverage	
☐ Employee Only	$3.37
☐ Employee & Spouse	$5.40
☐ Employee & Child(ren)	$5.51
☐ Employee & Family	$8.88

VOLUNTARY DISABILITY INSURANCE – rates are based on employee's age

Long Term Disability ☐ I elect coverage ☐ I decline coverage

Short Term Disability ☐ I elect coverage ☐ I decline coverage

PLEASE NOTE: If you request coverage at a later date, you will be required to furnish, at your own expense, proof of insurability, and the company reserves the right to reject your request.

BASIC LIFE & AD&D INSURANCE

TPC provides each employee basic life & AD&D insurance coverage of $50,000.

OPTIONAL TERM LIFE INSURANCE

Supplemental Term Life & AD&D (Please indicate your coverage selection)

EMPLOYEE

☐ **Coverage amount chosen:** $ _____

(**Please Note:** Optional life coverage is available in increments of $10,000, up to a maximum of $500,000, not to exceed 5 times annual earnings. Coverage amounts exceeding $100,000 require evidence of good health satisfactory to MetLife.)

☐ **No coverage chosen**

SPOUSE

☐ **Coverage amount chosen:** $ _____

(Available in increments of $5,000 at 50% of your Supplemental Term Life coverage, up to a maximum of $100,000. Coverage amounts exceeding $25,000 require evidence of good health satisfactory to MetLife.)

☐ **No coverage chosen**

CHILDREN

Coverage amount chosen: ☐ $1,000 ☐$2,000 ☐ $4,000 ☐ $5,000 ☐ $10,000

☐ **No coverage chosen**

PLEASE NOTE: In order to elect spouse and/or child optional life coverage you must elect optional life coverage for yourself. For additional plan information, please refer to the benefit summary.

INSURANCE BENEFICIARY DESIGNATION (Please complete even if Medical and Dental are waived)

Primary Beneficiary Name	Relationship	Social Security Number	% of Assets	Beneficiary Address (if different from yours)

Contingent Beneficiary Name	Relationship	Social Security Number	% of Assets	Beneficiary Address (if different from yours)

HSA CONTRIBUTION

If 55 years of age or older, you may elect to contribute an additional $1,000 catch up contribution for 2017 and 2018.

Contribution Election: $ _____ bi-weekly $ _____ lump sum

Individual Limits - $3,400 (2017) $3,450 (2018)
Family Limits - $6,750 (2017) $6,900 (2018)

IMPORTANT

I understand and have verified the benefit selections I have made and authorize any payroll deductions required for these selections. I also understand that the above selections for medical, dental, and vision (which are all pre-tax deductions) may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I understand that, by participating in any pre-tax plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. I also have read and understand the enrollment provisions, including restrictions stated on this form.

Details of each plan are contained in various insurance contracts and other legal documents. In the even of a conflict the contracts and plan documents prevail.

Compliance information is located on www.insuranceisboring.com. See HR for user name and password.

Printed Name: _____ Signature: _____ Date: _____