Residential CRF, Inc. Employer	1755 Group Number	Location/Plan	Sagamore PHCS/Florida PPO Network

ENROLLMENT: ☐ NEW ENROLLEE ☐ SPECIAL ENROLLEE ☐ LATE ENROLLEE ☐ OPEN ENROLLMENT

REQUEST FOR: ☐ NAME ☐ PHONE ☐ TERMINATION

CHANGE: ☐ ADDRESS ☐ EMAIL ☐ ADDITION

A. Employee Information

Last Name	First Name	Initial	Social Security Number
☐ Male ☐ Female — Birth Date	Home Phone	Work Phone	Extension
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated		E-mail Address	
Address – Street	City	State	Zip Code

B. Benefit Effective Date

Full-time Hire Date: ________________ **Date Benefits Became Effective:** ____________ **Termination Date:** ____________

C. Medical-Dental-Vision Benefit Options

☐ **Medical-Dental-Vision Plan**

D. Benefit Coverage Types

Medical-Dental-Vision: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

Note: ***If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the COURT DECREE with this form. If your dependent is disabled, please SUBMIT WRITTEN PROOF with this form.***

Dependents	Last Name	First Name	M.I.	Sex	Date of Birth	Social Security #	Effective Date:	Termination Date:
☐ Spouse								
☐ Child ☐ Court ordered								
☐ Child ☐ Court ordered								
☐ Child ☐ Court ordered								
☐ Child ☐ Court ordered								
☐ Child ☐ Court ordered								

Dependent Address, if different than the employee's address listed above. *(list dependent name and address)*

E. Election/Waiver – Please check all boxes that apply below.

☐ I authorize my employer to deduct any applicable Contribution amount to pay insurance premiums. I understand that based upon my filing status, I may receive additional tax credits under the IRS's Earned Income Credit Regulations. I further understand that:

- I will be given the opportunity once a year to decide on individual/family coverage. Once made, my decision cannot be changed for a full year unless there is a change in work or family status. If from year to year, I do not make changes; my coverage will stay the same with the new contribution automatically updated in my paycheck.
- I understand that I may be entitled to COBRA benefits if my employment is terminated.
- I understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.
- Pre-tax contributions reduce my pay for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.

☐ I do not wish to enroll in my employer's health plan at this time. I understand I may not be able to enroll again until open enrollment unless I have a special qualifying event.

☐ I am waiving medical-dental-vision coverage because I am covered through another medical plan. (See IMPORTANT note below.)

☐ I am waiving my spouse's medical-dental-vision coverage because he/she is covered by another medical plan. (See IMPORTANT note below.)

IMPORTANT:

IRS regulations stipulate that your benefit choices are locked in for the plan year unless you have a qualified change in status. You must report changes in status within 31 days of the event. Changes in status include:

- Marriage, divorce, or legal separation;
- Birth or adoption of your child;
- Death of your spouse or dependent;
- Status or loss of your spouse's employment that has an effect on benefits coverage – full-time to part-time; termination; new employment;
- Dependent's loss of eligibility (e.g. child reaches ineligible age) and/or spouse's open enrollment

You also have the right to request special enrollment if you or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and you request coverage within 60 days after eligibility is determined.

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F. Other Insurance Information

Are you or any of your dependents covered under another medical-dental or vision plan? ☐ No ☐ Yes *If yes, please complete the section below.*			
Other Company	Company's City, State	Policy ID #	Is this a COBRA policy? ☐ No ☐ Yes
Policyholder's Name	Policyholder's Employer	Dependents covered on the policy:	

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing 30 day prior written notice and only if it complies with government and IRS regulations.

I declare that the information I have furnished is true, complete and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purposes of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning.

Employee Signature:

____ **Date**________________