BENEFIT ELECTION FORM

Please return completed forms to: AmberH@qcihealthcare.com

QCI Healthcare

- Complete all portions of this form to make your benefit elections.
- **Forms must be completed and returned to QCI Healthcare within 30 days of eligibility or qualifying life event.**

Employee Information (all portions MUST be completed to process your elections)

Name		Phone #			
Email		Job Title			
Address, City, State, Zip		Date of Hire		Effective Date	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed	Annual Income	$	Hours Worked per Week	

Benefit Options please mark one box per line of coverage offered

2018 Medical Options	Single	Double	Family
Option 1: Blue Cross Blue Shield PPO **HSA** $4,000	☐ $26.53/week	☐ $151.22/week	☐ $204.66/week
Option 2: Blue Cross Blue Shield PPO $1,500	☐ $50.89/week	☐ $209.68/week	☐ $277.74/week
Option 3: Blue Care Network HMO $1,000	☐ $43.45/week	☐ $191.83/week	☐ $255.42/week
Option 4: Blue Care Network HMO 10%	☐ $60.65/week	☐ $233.11/week	☐ $307.02/week
☐ **Waive Coverage** - I do **NOT** want to participate in any of the Medical plans *(Reason for waiving must be provided below)*			

Health Savings Account (HSA) Contribution* (Available with Medical Option 1 ONLY)	
Annual Pre-Tax Contribution Amount	$

*Health Savings Account banking information must be provided to HR prior to 7/1 in order for pre-tax payroll contributions to take effect.

If waiving coverage, do you have other medical coverage?	Name of the Policy Holder & Relationship to Policy Holder	Health Insurance Carrier	Is your medical coverage through the Health Insurance Marketplace (www.healthcare.gov)?**
☐ Yes ☐ No	_____ _____	_____ _____	☐ Yes ☐ No

The Blue Cross Blue Shield PPO HSA $4,000 plan (option 1) offered by QCI Healthcare meets the Affordable Care Act (ACA) definition of affordability and minimum essential coverage. Due to QCI Healthcare offering a plan that meets these requirements, you (and your family) are **INELIGIBLE for a government subsidy on the Health Insurance Marketplace (Obamacare, Healthcare.gov). Should you decline the medical coverage and receive a subsidy from the Marketplace, you may be subject to a tax penalty.

Voluntary Delta Dental Coverage (100% EMPLOYEE Paid)

Single	Employee + Spouse	Employee + Child(ren)	Family
☐ $9.03/week	☐ $18.07/week	☐ $20.68/week	☐ $32.67/week
☐ **Waive Coverage** - I do **NOT** want to participate in the Dental plan			

Voluntary VSP Vision Coverage (100% EMPLOYEE Paid)

Single	Double	Family
☐ $3.43/week	☐ $5.24/week	☐ $9.40/week
☐ **Waive Coverage** - I do **NOT** want to participate in the Vision plan		

Complete other side of this page to finish your elections!

Voluntary Short Term Disability (100% EMPLOYEE Paid)	
Elect - coverage varies based on income. *(Please refer to the Benefits Guide for rate & policy information)*	☐
☐ **Waive Coverage** - I do **NOT** want to participate in the Voluntary Short Term Disability plan	

Voluntary Long Term Disability (100% EMPLOYEE Paid)	
Elect - coverage varies based on income. (*Please refer to the Benefits Guide for rate & policy information)*	☐
☐ **Waive Coverage** - I do **NOT** want to participate in the Voluntary Long Term Disability plan	

IMPORTANT NOTICE: Should you decline the Voluntary Disability coverages during this time, and choose to elect it at a later date, you will be required to submit medical questions and be subject to pre-existing condition limitations per the policy guidelines.

Enrollment Information (if you need more space, please attach a blank piece of paper to this form)

Name (Last, First, M.I.)	Social Security #	Gender	Date of Birth	Primary Care Physician Name & Address (only required if electing a BCN HMO plan)	Medical	Dental	Vision
Employee					☐	☐	☐
Spouse					☐	☐	☐
Child					☐	☐	☐
Child					☐	☐	☐
Child					☐	☐	☐

Signature Authorizing Payroll Deduction of Above Benefits

I hereby acknowledge and certify the above benefit elections; I understand that if I decide to waive my benefits I will be subject to any late entrant penalties that may apply if I decide to enroll at a later date. I also understand that since these deductions are performed on a pre-tax basis that all elections must remain the same until the next open enrollment unless I experience a qualifying life event. I acknowledge that for anyone who is covered under the medical policy and has other health benefits, I will disclose that information to the medical carrier. I acknowledge receipt of the Employee Benefits Guide which satisfies the annual Employee Disclosure and Medicare Creditable Coverage Notice requirement.

If you refuse coverage for yourself, you automatically refuse that coverage for any dependents. If you are declining enrollment for any of the benefits offered you may in the future be able to enroll yourself and your dependents in the plan, during annual enrollment or within 30 days after a qualifying life event. **If you decide to waive the short and/or long term disability coverages when you are first eligible, you may be subject to medical underwriting and pre-existing conditions limitation exclusions.**

By signing below, I acknowledge that the information on this enrollment form is true and that I have received and read all documents as noted above.

Employee Signature: _____ **Date:** _____