Rocky Mountain UFCW Unions & Employers Health Benefit Plan

2021 Enrollment, Payroll Deduction Authorization and Waiver Form

5511 West 56th Avenue, Suite 250, Arvada, Colorado 80002 Mailing Address: P.O. Box 447, Arvada, Colorado 80001-0447 303-430-9334 or 800-527-1647

See your *2021 Enrollment Guide* for useful information. Please complete, sign, and return this form to the Plan Office. Print all information.

Employee Information

Employee Full Name: _____ Employee SSN: _____

Address **(No P.O. Boxes):** _____ Home Phone #: _____

City: _____ State: _____ Zip Code: _____ Alternate/Mobile Phone #:_____

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Email Address: _____

Waive Coverage

If you are currently covered by the Plan and wish to waive coverage for yourself and your eligible dependents in 2021, you must indicate that election here and then sign the Employee Authorization section of this form.

☐ **I wish to WAIVE coverage** for myself and my dependents effective January 1, 2021. (Skip to the Employee Authorization section of this form.)

☐ **I wish to ELECT coverage** for myself and my dependents effective January 1, 2021. (Complete the rest of this form, as applicable.)

Dependent Information (List all dependents you want to cover or remove from coverage in 2021)

Use this section to list your eligible dependents that you want to cover in 2021 or that you want to terminate from coverage. If you are covering dependents, the Plan Office will contact you for the required documents. Attach an additional page if needed. Be sure to provide all requested information.

Spouse ☐ Electing 2021 coverage ☐ Removing from coverage in 2021

Full Name: _____ Spouse SSN: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

If you're electing coverage for your spouse, is your spouse employed? ☐ No ☐ Yes. If yes, please provide the following:

Employer Name: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Is health coverage available to your spouse through his/her employer? ☐ No ☐ Yes If yes, is your spouse enrolled in his/her employer's plan? ☐ No ☐ Yes

Dependent Child ☐ Electing 2021 coverage ☐ Removing from coverage in 2021

Full Name: _____ Dependent SSN: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Natural Child ☐ Adopted Child ☐ Stepchild ☐ Other_____ Full-Time Student: ☐ No ☐ Yes

Address (if different address than participant) **(No P.O. Boxes):** _____

City: _____ State: _____ Zip Code: _____

Is your dependent married? ☐ No ☐ Yes

Dependent Child ☐ Electing 2021 coverage ☐ Removing from coverage in 2021

Full Name: _____ Dependent SSN: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Natural Child ☐ Adopted Child ☐ Stepchild ☐ Other_____ Full-Time Student: ☐ No ☐ Yes

Address (if different address than participant) **(No P.O. Boxes):** _____

City: _____ State: _____ Zip Code: _____

Is your dependent married? ☐ No ☐ Yes

*Kaiser's definition of Dependent differs for a stepchild or a child under legal guardianship. Kaiser also offers coverage to civil union partners. Call the Plan Office for information.

Other Health Coverage Information

If you, your spouse, or any of your dependent children have other medical coverage, you must complete this section and provide the requested information.

Covered Individual's Name	Other Coverage	Insurance Company Policy/ID#	Effective Date

If you or a dependent are eligible to enroll in Medicare, complete the following:

		Effective Date			
Enrollee's Name	Medicare ID #	Part A	Part B	Part D	ESRD Onset

Beneficiary Designation for Death Benefits (Effective upon receipt by the Plan Office)

Primary Beneficiary(ies): I, the undersigned, hereby revoke any and all prior beneficiary designations made by me with respect to the Rocky Mountain UFCW Unions & Employers Health Benefit Plan and hereby direct that any benefits payable under the Plan upon my death be paid to the following primary beneficiary (or equally to the following primary beneficiaries).

Name	Social Security No.	Relationship	Address	Phone Number

Contingent Beneficiary(ies): In the event all of the above named beneficiaries die or disclaim before the full amount of benefits, if any, has been paid, I direct that my entire remaining interest in the Plan be paid to the following contingent beneficiary (or equally to the following contingent beneficiaries).

Name	Social Security No.	Relationship	Address	Phone Number

Program Option Election

I elect coverage under the following Rocky Mountain UFCW Unions & Employers Health Benefit Plan program option:

☐ **PPO Medical Plan Option.** This option provides medical benefits through the UnitedHealthcare/UMR Preferred Provider Organization (PPO) and prescription drug benefits through Express Scripts.

☐ **Kaiser Permanente HMO Medical Plan Option.** This option provides insured medical and prescription drug benefits through Kaiser Permanente.

Coverage Level Election and Payroll Deduction Authorization

By selecting one of the following options and signing and submitting this form, I understand that if I elect not to enroll myself and/or a dependent in the Plan at this time, I will not be able to enroll myself and/or my dependent until the next open enrollment period, unless I experience a special enrollment event, as detailed in the *Notice of Special Enrollment Rights* in your *2021 Enrollment Guide*. I also understand that by electing coverage on this form, I authorize my employer to deduct the applicable weekly co-premium from my weekly paycheck. The weekly co-premiums effective January 1, 2021 are listed below.

☐ **Employee-Only.** I elect coverage under the Plan and, by signing this form, authorize my employer to deduct **$7.50** per week from my weekly paycheck for Employee-Only coverage.

☐ **Employee and Child(ren).** I elect coverage under the Plan and, by signing this form, authorize my employer to deduct **$15.00** per week from my weekly paycheck for Employee and Child(ren) coverage for the children I elected 2021 coverage for on the front of this form. I understand that to elect this coverage I must complete the *Dependent Information* section on this form.

☐ **Employee and Spouse.** I elect coverage under the Plan and, by signing this form, authorize my employer to deduct **$15.00** per week from my weekly paycheck for Employee and Spouse coverage for the spouse I elected 2021 coverage for on the front of this form. I understand that to elect this coverage I must complete the *Dependent Information* section on this form as well as the *Spousal Coverage Verification* section.

☐ **Employee, Spouse, and Child(ren).** I elect coverage under the Plan and, by signing this form, authorize my employer to deduct **$23.00** per week from my weekly paycheck for Employee, Spouse and Child(ren) coverage for the spouse and child(ren) I elected 2021 coverage for on the front of this form. I understand that to elect this coverage I must complete the *Dependent Information* section on this form as well as the *Spousal Coverage Verification* section.

Spousal Coverage Verification/Additional Working Spouse Co-Premium (To be completed if electing spousal coverage; also complete the enclosed Spousal Coverage Verification form)

Select one of the following if you elected "Employee and Spouse" or "Employee, Spouse, and Child(ren)" in the last section.

☐ My spouse is either (1) not employed; (2) employed and his/her employer does not offer health coverage; or (3) employed and is currently enrolled or will be enrolled before January 1 in his/her employer's plan.

☐ My spouse is employed but will not be able to enroll in his/her employer's plan until _____ (date spouse will be eligible for coverage). If my spouse fails to enroll in his/her employer's plan effective as of that date, I authorize my employer to deduct an additional **$23.08** from my weekly paycheck.

☐ My spouse is employed and will not be enrolling in his/her employer's plan. I authorize my employer to deduct an additional **$23.08** from my weekly paycheck.

YOU MUST ALSO COMPLETE THE SPOUSAL COVERAGE VERIFICATION FORM.

Employee Authorization

I understand this election will be effective as of January 1, 2021 and will remain in effect until changed by me during a subsequent open enrollment or upon the occurrence of a special enrollment event, as described in the *Notice of Special Enrollment Rights*. I also understand and acknowledge that the applicable weekly co-premium for the elected benefits may be increased or decreased and completion of this enrollment form is not a guarantee of eligibility or benefits. If I have elected coverage under the Kaiser Permanente HMO Program, I hereby authorize Kaiser Permanente to bill my spouse's or any other dependent's primary group insurance carrier for all services provided or arranged by Participating Physicians and to coordinate benefits and/or reimbursements with other health or insurance companies. I request that payment be made to Kaiser Permanente on any bills for services furnished for myself or any dependents on my plan. I also authorize Kaiser Permanente to release any information regarding the medical treatment needed for this claim. **I hereby certify that the foregoing information, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.**

Employee Name (print): _____

Employee's Signature: _____ Date: _____

In the event you elect the Kaiser Permanente HMO Program and it is determined that you do not reside in an area covered by Kaiser Permanente, you will automatically become covered under the Rocky Mountain UFCW Unions & Employers Health Benefit Plan PPO Medical Plan Option. In addition, the completion of this enrollment form is not a guarantee of eligibility or benefits. In general, your eligibility and the level of benefits you are eligible to receive are based upon your employer contributing to the Plan on your behalf and the amount of that contribution. **Kaiser Foundation Health Plan of Colorado Enrollment Application Provisions/Disclosures.** C.R.S. 10-1-128 (6)(a): 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 false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.