

2017 BENEFIT ELECTION FORM

Worksite Employer: _____

Effective Date: _____

Return Completed Forms to: MMC Benefits Department via email: Benefits@MMChr.com, or Fax: 310-360-5100, Phone: 800-899-6624

- New Enrollment
 Open Enrollment
 Change of Status Date _____
 Rehire Date _____
 Part-Time to Full-Time Employment Date _____
 Family Addition
 COBRA
 Other _____

EMPLOYEE ENROLLMENT (Complete in Full)					
Employee Name (Last, First, Middle Initial)			Social Security Number		Date of Hire (mm/dd/yy)
Employee Street Address	Apt #	City	State	Zip	Home Phone
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yy)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)		Email	
Decline Coverage: <input type="checkbox"/> Waive Medical <input type="checkbox"/> Waive Dental <input type="checkbox"/> Waive Vision <input type="checkbox"/> Waive Optional Life <input type="checkbox"/> Waive FSA <input type="checkbox"/> Decline Due to Other Coverage (Insurance Carrier Name): _____; or <input type="checkbox"/> Decline Due to Other reasons: _____					

FAMILY STATUS CHANGE	DATE OF FAMILY STATUS CHANGE EVENT: _____
Changes outside of Open Enrollment must be related to an event that allows for special enrollment. Employees must submit a completed form and required documentation within 31 days of the qualifying change in family or employment status. Check the event(s) that triggered the change:	
<input type="checkbox"/> Spouse, partner, or child added due to marriage/civil union, birth, adoption, legal custody, court order, or medical support order. <input type="checkbox"/> Spouse, partner, or child is no longer eligible dependent due to divorce, legal separation, dissolution of civil union, death, or other loss of eligibility. <input type="checkbox"/> Dependent child attains maximum age limit. <input type="checkbox"/> Change of eligibility due to gain or loss of coverage under another group health insurance. <input type="checkbox"/> Change in employment status of employee, or eligible dependent or a change in residence that affects health plan availability.	

BENEFIT ELECTIONS (Medical, Dental, Vision) – Anthem Blue Cross					
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MEDICAL					
Coverage Category	Department Code: _____	Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
Anthem Premier HMO \$10 copay	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem Premier HMO \$20 copay	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem Premier HMO \$35 copay	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vivity HMO Network – for above HMO plans, check if selecting Vivity HMO Network (if offered by your employer)					
Anthem Premier PPO \$250 / \$15 / 10%	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem Classic PPO \$500 / \$20 / 20%	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem LumenosHSA \$2600 / 0% / 30%	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem LumenosHSA \$1300/2600 / 10% / 30%	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem LumenosHSA \$3000 / 20%/40%	Group# 279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL					
Coverage Category		Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
Anthem Dental Complete PPO	Group #279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem Dental Net DHMO	Group #279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VISION					
Coverage Category		Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
Anthem Blue View Vision	Group #279724 – _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COVERED INDIVIDUALS

Appropriate documentation such as copy of tax return, marriage certificate or Domestic Partner (DP) affidavit, and birth certificate must be submitted upon enrollment to verify dependent eligibility.

NAME (Last, First, Middle Initial)	Coverage	Gender	For children age 26 or over: IRS Qualified Dependent?	Date of Birth	SSN#	Anthem HMO Provider ID#	Existing MD?	Dental HMO Provider ID#
SELF	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Spouse <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> DP Name: _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N	
Child Name <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	
Child Name <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	
Child Name <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	
Child Name <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	

COBRA COVERAGE INFORMATION – COMPLETE ONLY IF ENROLLING IN COBRA

Reason for COBRA coverage _____

Federal COBRA qualifying event date	Federal COBRA coverage begin date	Federal COBRA coverage end date
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PRIOR COVERAGE (for PPO Plans Only)

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Self					
<input type="checkbox"/> Spouse <input type="checkbox"/> DP					
Child					
Child					

Coordination of Benefits: Do you or your dependents have other health plan or health insurance (including Medicare)? Yes No

Is the other coverage primary? Yes No

If yes, please provide the following information on the person & health plan providing other coverage:

Subscriber Name: _____ Effective Date: _____

Carrier Name: _____ Group/Policy #: _____

BASIC LIFE AND AD&D - Anthem Blue Cross Life & Health Life Class 1 #279724C001 / AD&D Class 1 #279724B001

Your employer provides a Basic Life and Accidental Death & Dismemberment benefit of 1 x Base Annual Salary, up to a maximum of \$500,000. Benefit reduces by 35% at age 65; 50% at age 70. Human Resources Entry Only - Annual Salary: \$ _____ Elect

OPTIONAL LIFE - Anthem Blue Cross Life & Health		Employee Only #279724S001 / Employee + Spouse #279724SF01 Employee + Child(ren) #279724SF01 / Employee + Spouse + Child(ren) #279724SF01
Additional Optional Life Insurance is available for you and your dependents. An Evidence of Insurability Form for each applicant must be completed and approved for Optional Life amounts elected above the Guarantee Issue amount, and for enrollments or increases after your initial enrollment period. Benefit availability is subject to participation minimum.		
Employee Optional Coverage \$10,000 increments, max lesser of 5 x Salary or \$500,000 Guarantee Issue: \$50,000	Spouse/DP Optional Coverage \$5,000 increments, max \$250,000 <i>(Not to exceed 50% of Employee Optional Coverage)</i> Guarantee Issue: \$25,000	Child(ren) Optional Coverage Flat \$5,000 or \$10,000 per unit
Employee Optional Coverage Amount \$ _____	Spouse/DP Optional Coverage Amount \$ _____	Child(ren) Optional Coverage Amount <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000

HEALTH SAVINGS ACCOUNT (HSA) - TASC
To participate in a HSA account, you must make a new election each year by annually completing a new TASC Enrollment Form. Once you make your election, you may not change your contribution until the next Open Enrollment unless a qualifying family status change occurs.
<p>Health Savings Account – HSA</p> <p><input type="checkbox"/> Elect (<i>attach completed TASC Enrollment Form</i>) <input type="checkbox"/> Decline</p> <p>Maximum annual contribution: \$3,400/year Individual, \$6,750/year Family; You must be enrolled in a Lumenos HSA compatible medical plan*</p>

*To be eligible to contribute to a Health Savings Account (HSA), you must be enrolled in an HSA compatible medical plan, known as a High Deductible Health Plan (HDHP), and you may not be enrolled in any other coverage that is not an HSA compatible plan (such as HMO, non-high deductible PPO, or FSA through yourself or spouse). Consult with your tax advisor if you are unsure of your eligibility to contribute to an HSA.

SIGNATURE REQUIRED ON BOTH SECTIONS OF FOLLOWING PAGES

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

- 1 The date eligibility for COBRA Continuation Coverage ends, or
- 2 The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
- 3 The date your employer discontinues coverage with Anthem Blue Cross, or
- 4 The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
- 5 The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Employee Signature	Date	HR Use Only Entered:
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Signature Required for Anthem Blue Cross Plan Enrollees

Date

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements. I also certify that the information I provided on this form and at all times during coverage about my family status and my dependents' eligibility for benefits under the benefit plan is accurate. I understand that coverage may be rescinded in the event of fraud or a material misrepresentation, and such rescission is effective on the date of such fraud or misrepresentation.

FRAUD WARNING: I further understand that any person who knowingly, and with intent to defraud any insurance company, or other person, files an application for insurance or a statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DEDUCTION AUTHORIZATION: I authorize my employer to deduct from my wages the required subscription charges/premiums on a pre-tax basis as determined by the benefits that I have chosen. If my employment terminates, I authorize my employer to make any required payroll deductions associated with my benefit elections from my final paycheck. I understand that the benefits that I have elected will be in effect through December 31, 2017 or until a new election is received due to a qualifying family status change or subsequent open enrollment period. **I understand I have 30 days from the qualifying event to notify the MMC Benefits Department. I also am responsible for notifying MMC of dependents that are no longer eligible within 30 days of the qualifying event. Failure to do so may jeopardize my dependent's right to elect COBRA.**

LEAVE OF ABSENCE: If you are on an approved federal or state leave of absence, you may choose to continue participation during your leave by making payments directly to us. This will allow you to submit eligible expenses incurred during your leave. If you do not continue to make direct payments during your approved leave of absence, your participation under the plan ends at the end of the pay period in which your last contribution is deducted from your paycheck. Please contact the MMC Benefits Department at (800) 899-6624 if you become aware of the need for a leave of absence so we can explain the options available.

Employee Signature Required

Date

Beneficiary Designation Form

Return Completed Forms to: MMC Benefits Department via email: Benefits@MMChr.com, Fax: 310-360-5100, Phone: 800-899-6624

Select one of the following:

- Designation for Group Life Policy Only
- Designation for Supplemental Life Policy Only
- Designation for both Group and Supplemental Life Policies

Insured First Name	Middle Name	Last Name	
Insured Street Address	City	State	Zip
Insured Social Security Number	Home Phone	Cell Phone	Date of Birth (dd/mm/yyyy)
Insured Home Email		Worksite Employer	

Definitions/Statements: Primary Beneficiary means the person or persons who will receive the benefits in the event of the Insured's death. Proceeds will be divided in equal shares if multiple beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%. Contingent Beneficiary means the person or persons who will receive the benefits if the primary beneficiary is not living at the time of the Insured's death. Proceeds will be divided in equal shares if multiple beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%.

Beneficiary Information

Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	% Designation
Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	% Designation
Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	% Designation
Beneficiary First Name	MI	Last Name	Social Security Number	Birth Date	Relationship
Beneficiary Street Address, City, State, Zip				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	% Designation
Other – Estate of Insured, Revocable or Irrevocable Trust, and Trustee Under Insured's Will				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	% Designation

Should I survive all of the persons named on this form, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to MMC all in accordance with the applicable provisions of law. **BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE PREVIOUS DESIGNATION I MAY HAVE FILED.**

Insured Signature	Date
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