Effective Date: ________________

St. Mary's General Hospital JNESO

- ☐ New Enrollment
- ☐ Rehire Date ________________
- ☐ Change of Status Date ________________
- ☐ Open Enrollment
- ☐ Other ____________________________

2024 BENEFITS ELECTION FORM

For dependent coverage, you will be required to provide documentation such as: most recent Tax Return, Birth Certificate, Declaration of Civil Union or Court Documents, depending on circumstances.

SECTION 1 EMPLOYEE ENROLLMENT (Complete in Full)

Employee Name (Last, First, Middle)	Social Security Number (SS#)	Birth Date (mm/dd/yy)	☐ Male ☐ Female
Employee Street Address City State Zip		Home Phone	Work Phone

Emergency Contact: Name	Phone No.	Relationship	Marital Status
Date of Hire (mm/dd/yy)	Annual Salary	Hours Worked / Pay Period	Employee Type ☐ Full Time ☐ Part Time

Coordination of Benefits: Do you or any of your dependents have any other health plan or health insurance (including Medicare) in addition to the Prime Medical Coverage? ☐Yes ☐ No

If yes, will this coverage remain in effect after the Prime Medical coverage begins? ☐ Yes ☐ No
Name and Group number of other Coverage ____________________________

SECTION 2 BENEFIT ELECTIONS

MEDICAL	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Prime EPO Plan	☐	☐	☐	☐
Prime EPO Plus Plan	☐	☐	☐	☐
Prime Value Plan	☐	☐	☐	☐

DENTAL	Employee Only	Employee + 1 Dependent	Employee + Family
Delta Dental PPO Plan	☐	N/A	☐
Delta Dental PPO Plus Premier Plan	☐	N/A	☐
DeltaCare USA 12A Plan	☐	☐	☐

VISION	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Davis Vision	☐	☐	☐	☐

SECTION 3 COVERED INDIVIDUALS (Please print Names, Birthdates and Social Security Numbers)

Name (Last, First, Middle Initial)	Gender	Relationship	Birth Date	SS# (Required)	Primary Care Physician ID#	DeltaCare 12 A Provider ID#
SELF	☐ M ☐ F	SELF				
☐ Add ☐ Delete	☐ M ☐ F	☐ SPOUSE ☐ CIVIL UNION				

☐ Add ☐ Delete	☐ M ☐ F	CHILD ☐ Disabled?				
☐ Add ☐ Delete	☐ M ☐ F	CHILD ☐ Disabled?				
☐ Add ☐ Delete	☐ M ☐ F	CHILD ☐ Disabled?				

☐ I decline all health plan coverage for myself, spouse and all dependents

I decline ☐ Medical ☐ Dental ☐ Vision coverage for:
☐ Spouse only ☐ Child(ren) only ☐ Spouse and Child(ren) only

☐ The following Dependents only: ______________________________

☐ I have other medical coverage: Name of Insurance Carrier ______________________________

SECTION 4 LIFE, AD&D, LONG TERM & SHORT TERM DISABILITY (LTD & STD) INSURANCE - SUN LIFE FINANCIAL METLIFE LEGAL PLANS / FINANCIAL WELLNESS & IDENTITY PROTECTION - EXPERIAN FLEXIBLE SPENDING ACCOUNT – HR SIMPLIFIED

Coverage Election – Complete the boxes by checking them to indicate your Coverage Elections.

- All the coverages listed may not be offered under your plan.
- Some amounts may be subject to Evidence of Insurability

Please see the Sun Life highlight sheet for plan details and rates.

MetLife Legal Plan - $7.62 Bi-weekly
Experian – $2.88 Individual /$5.54 Family Bi-weekly
FSA – Medical Savings Account ($3,050 max)
FSA – Dependent Day Care Account ($5,000 max)

	Elected	Declined	
Life/AD&D (Full-Time EE's only) (Part-Time Nurses only)	☒	N/A	1x annual salary up to $150,000 JNESO Tech/ up to $100,000 JNESO RN's Flat $5,000
Optional EE Life	☐	☐	$__________
Optional Spouse Life	☐	☐	$__________
Optional Child Life	☐	☐	$__________
V-LTD	☐	☐	$__________
V-STD	☐	☐	$__________
Legal Plan	☐	☐	$__________
Experian	☐	☐	$__________
FSA Medical	☐	☐	$__________ (Annual Election)
FSA Day Care	☐	☐	$__________ (Annual Election)
FSA Commuter	☐	☐	$__________ (Annual Election)

BENEFICIARY DESIGNATION

Primary Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit
Primary Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit
Contingent Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit
Contingent Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit

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 Prime Healthcare Services to take the appropriate payroll deduction on a pre-tax basis from my wages 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 January 1 through December 31, 2024 or until a new election is received due to qualifying event or subsequent open enrollment period. I understand I have 30 days from the qualifying event to notify Human Resources. I also am responsible for notifying Human Resources 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.

Employee Signature >	Signature of witness (only required if employee signature is "X")	Date	HR Use Only Entered: