Medical and Dental Enrollment Form

EMPLOYEE INFORMATION

Last Name_____ **First Name**_____ **Sex:** ☐ Male ☐ Female

Address _____ **City** _____ **State**_____ **Zip Code** _____

Date of Hire_____ **Benefits Eligibility Date** _____ **Date of Birth** _____

ENROLLMENT/CHANGES: ☐ **New Enrollment** ☐ **Open Enrollment** ☐ **Life Event Change** **Effective Date:** _____/_____/_____

MEDICAL - PPO: Check only one box

	Monthly Cost
☐ Employee Only:	$131.80
☐ Employee + 1 Dependent:	$369.40
☐ Family:	$554.30

OR

MEDICAL – HDHP with HSA: Check only one box

	Monthly Cost
☐ Employee Only:	$ 87.50
☐ Employee + 1 Dependent:	$276.60
☐ Family:	$422.70

HSA Monthly Contribution Amount $_____ *(optional)*

HSA Monthly Catch-Up Contribution Amount $_____

OR

MEDICAL

☐ **Decline Medical Coverage**

DENTAL - STANDARD: Check only one box

	Monthly Cost
☐ Employee Only:	$10.20
☐ Employee + 1 Dependent:	$24.90
☐ Family:	$37.00

OR

DENTAL - ENHANCED: Check only one box

	Monthly Cost
☐ Employee Only:	$15.70
☐ Employee + 1 Dependent:	$36.90
☐ Family:	$55.40

OR

DENTAL

☐ **Decline Dental Coverage**

Premium payments for the full monthly cost of medical coverage are due the first of the month for the current month's coverage. Typically, payments will be made automatically through payroll deduction. However, employees who do not work enough hours to pay the Monthly Cost listed above must make arrangements to pay the difference on an after-tax basis (e.g., by personal check). All employees will be responsible for monitoring payment of premiums and for timely remitting any outstanding balances to Vi. Failure to pay the full amount due 30 days after the due date may result in retroactive cancellation of medical coverage.

CANCELLATION OF COVERAGE: ☐ **Open Enrollment** ☐ **Life Event Change** **Effective Date:** _____/_____/_____

MEDICAL - PPO: ☐ Employee Only ☐ Employee + 1 Dependent ☐ Family **DENTAL - Standard:** ☐ Employee Only ☐ Employee + 1 Dependent ☐ Family

MEDICAL - HDHP: ☐ Employee Only ☐ Employee + 1 Dependent ☐ Family **DENTAL - Enhanced:** ☐ Employee Only ☐ Employee + 1 Dependent ☐ Family

OVER

DEPENDENT INFORMATION - List all eligible dependents to be covered / cancelled from coverage. ***All fields must be completed when covering dependents.***

MEDICAL - Enroll	MEDICAL - Cancel	DENTAL - Enroll	DENTAL - Cancel	Name (Last, First)	Social Security Number	Date of Birth	Relationship
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				

I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize the company to deduct from my pay on a pre-tax basis and remit any required contribution for the cost of coverage. This authorization is to remain in effect until I notify the company in writing of any changes. I also understand that I cannot change my benefit elections or cancel my coverage until the next Open Enrollment period unless I have experienced a Life Event as defined by the Plan. *If canceling medical coverage, I hereby certify that I and any eligible dependents currently enrolled in medical benefits have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the Vi's medical coverage is revoked.*

If electing coverage under the High Deductible Health Plan (HDHP), I understand and agree that, in order to be eligible to make or receive tax-favored contributions to my Health Savings Account (HSA) for a particular month, on the first of that month:

- I must be covered by the qualified HDHP.
- I may not be covered by any other non-HSA-compatible health plan, including Medicare Parts A and B and a general purpose health care flexible spending account (it is ok to enroll in the limited purpose health care flexible spending account offered by Vi).
- I am not covered by TriCare or Medicaid.
- I have not received medical benefits (other than permitted coverage or preventive care) from an Indian Health Services facility during the past three months.
- I am not claimed as a dependent on another person's tax return (but may be a spouse filing jointly).

I understand that the HSA is an individually-owned account that I am responsible for managing, including responsibility for filing Form 8889.

Subrogation - I also agree to the Subrogation provisions described below.

If the Plan pays benefits for a sickness or injury that was caused by an act or omission of a third party, the Plan will be "subrogated" to all of your rights of recovery. "Subrogated" or "Subrogation" means the Plan may take your place (or "stand in your shoes") in pursuing your legal rights or a legal claim against the third party or your right to any recovery pursued on your behalf by the Plan or anyone else. If you receive benefits under the Plan for a sickness or injury that was caused by an act or omission of a third party, you must immediately notify the Claim Administrator of the name of any third party against whom you might have a claim as a result of your sickness or injury.

A third party includes any person or organization (including an insurance company) that is not the sick or injured Plan participant. For example, if you are injured in an automobile accident and the person who hit you was at fault, the person who hit you is the third party whose act or omission caused your sickness or injury. Additionally, the insurance company of the person who hit you is a third party that may be liable for the act or omission that caused your sickness or injury.

By accepting benefits under the Plan, you agree to this subrogation provision (as well as the other provisions of the Plan), including that you:

- Automatically assign to the Plan (you "subrogate") any right to recover payments and any actual recovery from any third party.
- Agree to notify the Claim Administrator when a third party may be liable for a sickness or injury covered under the Plan. You further agree to notify the Claim Administrator within 30 days of making any claim relating to that third party's liability. Failure to notify the Claim Administrator will suspend benefit payments for the applicable sickness or injury. Such suspension will be lifted when you sign the agreement discussed below.
- Recognize the Plan's right to recover its payment for Plan expenses from the third party who caused and/or is liable for the sickness or injury related to the Plan's benefit payments.
- Agree to cooperate with the Plan to provide information about your sickness or injury and otherwise do whatever is necessary to secure the Plan's subrogation right, including signing any necessary documents for the Plan to fully subrogate your claim.
- Agree to cooperate fully with the Plan in collecting from the person who caused the sickness or injury. (If a claim is settled without protecting the Plan's interests, your rights to full compensation may be lost.)
- Agree to refrain from any action or inaction that may prejudice the Plan's ability to obtain recovery from you or the third party.
- Agree that no settlement proceeds will be distributed unless and until the Plan's interest has been paid to the satisfaction of the Plan's fiduciaries.

_____ _____

Employee Signature **Date** **Human Resources Approval** **Date**