Patient • Physician Network Holding Co., L.L.C.

*A Medical Service Organization Dedicated to Optimizing the Patient / Physician Relationship*

# BENEFITS ENROLLMENT FORM

## PRACTICE INFORMATION

| | |
|---|---|
| **PRACTICE NAME**: | **OFFICE MANAGER**: |
| **MANAGER'S PHONE NUMBER**: | **EMAIL:** |

## ENROLLMENT INFORMATION

| | | | | |
|---|---|---|---|---|
| **REASON FOR ENROLLMENT:** | ☐ New Hire | ☐ Open Enrollment | ☐ Qualifying Event | |
| **COVERAGE SELECTED:** | ☐ Dental | ☐ Vision | ☐ Life | |
| **STATUS CHANGE:** | ☐ Add Dependent | ☐ Delete Dependent | ☐ Address Change | ☐ Termination |

## PERSONAL INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Employee's Full Name | | SSN | | Occupation | Salary |
| Home Address | | City | State | Zip Code | County |
| Home Phone | Work Phone | Employee's Email Address: | | Date of Birth | Date of Hire |
| Gender<br>☐ Male ☐ Female | Marital Status<br>☐ Single ☐ Married | Primary Language<br>☐ English ☐ Spanish ☐ Other<br>_____ | | Hours Worked Per Week | |

## DENTAL PLAN

| Effective Date: | **United Concordia Low (MAC) In-Network (New $3000 Annual Max with Smile for Health Wellness Benefit)** | **United Concordia High (R & C) Out-of-Network (New $3000 Annual Max with Smile for Health Wellness Benefit)** |
|---|---|---|
| ☐ Employee Only | ☐ $41.57 | ☐ $41.57 |
| ☐ Employee +1 | ☐ $79.08 | ☐ $79.08 |
| ☐ Employee +2 or More | ☐ $135.93 | ☐ $135.93 |

## DEPENDENTS TO BE COVERED

| Name of Person to be Covered<br>Last First Middle | SS # | Gender | Date of Birth | Resides with Employee |
|---|---|---|---|---|
| Spouse | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |
| Child | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |
| Child | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |
| Child | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |

## VISION PLAN

| Effective Date: | **MetLife Vision** |
|---|---|
| ☐ Employee Only | ☐ $7.01 |
| ☐ Employee +1 | ☐ $13.31 |
| ☐ Employee +2 or More | ☐ $17.86 |

## DEPENDENTS TO BE COVERED

| Name of Person to be Covered<br>Last First Middle | SS # | Gender | Date of Birth | Resides with Employee |
|---|---|---|---|---|
| Spouse | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |
| Child | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |
| Child | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |
| Child | | ☐ Male<br>☐ Female | | ☐ Yes<br>☐ No |

# LIFE INSURANCE

**Metlife Life Insurance**
See Rate Table for Premium Amounts

Optional Term Life (Please indicate your coverage selection)

**EMPLOYEE**

☐ **Life amount chosen:** $ _____ ☐ Enrollment Increase in Coverage $ _____

**Please Note: Optional life coverage is available in increments of $10,000; guarantee issue is a maximum of $150,000 if employee elects during their initial eligibility period. Overall benefit maximum, not to exceed $500,000 or five times your annual salary.**

☐ **Waived**

**SPOUSE**

☐ **Life amount chosen:** $ _____ ☐ Enrollment Increase in Coverage $ _____

**Name:** _____ **SS#**_____ **DOB:**_____

**Please Note: Optional life coverage is available in the amount of $25, 000 without EOI upon initial enrollment. Spouse coverage can be added or increased, but will require EOI for any amount over the guarantee Issue. Spouse may apply for up to $100,000 (with medical underwriting) or 50% of employees.**

☐ **Waived**

**CHILDREN:**
**Guaranteed, if elected during your initial new hire eligibility period. Children are covered up to the age of 26. One rate is inclusive of all children.**
**15 days to six months $1,000. More than six months $1k, $2k, 4k, $5k or $10k**

☐ _____**Life amount chosen: Max $10,000.**

**Name:** _____ **SS#**_____ **DOB:**_____
**Name:** _____ **SS#**_____ **DOB:**_____
**Name:** _____ **SS#**_____ **DOB:**_____
**Name:** _____ **SS#**_____ **DOB:**_____

☐ **Waived**

**PLEASE NOTE: In order to elect spouse and/or child optional life coverage you must elect optional life coverage for yourself.**

Annual Salary Amount $_____
***Must have annual salary in order to enroll in the life plan.***

**LIFE INSURANCE BENEFICIARY DESIGNATION**

| **Primary Beneficiary Name** | **Relationship** | **Social Security Number** | **% of Assets** | **Beneficiary Address** (if different from yours) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| **Contingent Beneficiary Name** | **Relationship** | **Social Security Number** | **% of Assets** | **Beneficiary Address** (if different from yours) |
| | | | | |
| | | | | |
| | | | | |

**IMPORTANT**

I understand and have verified the benefit selections I have made and authorize any payroll deductions required for these selections. I also understand that the above selections for, dental, vision and voluntary life (which may be pre-tax deductions) may not be changed during the year unless I have a qualified change in family status as defined by the Internal Revenue Service. I understand that any requests for such a change must be submitted in writing to my Benefits Contact within 31 days of the qualifying event. I understand that, by participating in any pre-tax plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. I also have read and understand the enrollment provisions, including restrictions stated on this form.

Printed Name: _____ Signature: _____ Date: _____

**Please note any missing information on this enrollment form in its entirety may delay your enrollment into the plans.**

**Effective dates will always be on the 1st of the month.**

**Terminations are always on the last day of the month.**

Please be aware, if your carriers are not notified of a employees termination of the plan before the last day of the month in which the termination occurred then the carrier will continue to charge you for that employee until they are notified, which could involve your organization being charged for a premium for an employee who is not longer active on the plan. This will also affect the date the employee is subject to either COBRA or state continuation, whichever applies.