Hog Slat/BCBSNC Health Plan Enrollment Form

Employee Name (Last, First, MI)	Employee Number

Please check one of the following:

☐ I AM ENROLLING MYSELF AND/OR MY DEPENDENTS IN THE HOG SLAT HEALTH PLAN **(CONTINUE TO FILL OUT FORM)**

☐ I AM WAIVING ENROLLMENT FOR MY MYSELF/DEPENDENTS IN THE HOG SLAT HEALTH PLAN OR I DO NOT WISH TO ENROLL AT THIS TIME. I MAY VOID THIS ELECTION FORM & CHOOSE TO ENROLL BY COMPLETING A NEW ENROLLMENT FORM WITHIN 60 DAYS OF MY HIRE DATE. **(STOP HERE AND SIGN ON LINE BELOW)**

I DECLINE HEALTH COVERAGE: SIGN: ____ **DATE:**_____________

Address: Street	**City**	**State**	**Zip Code**	**Phone Number** ( ) -

Emp. Date of Birth Mo Day Year	**Date of Hire** Mo Day Year	**Marital Status** ☐ Married ☐ Single	**Sex** ☐ Male ☐ Female
SSN	**Type of Enrollee:** ☐ New Hire Enrollment ☐ Annual Enrollment	☐ **Special Enrollee** (qualifying event) **Reason:** ____________________ **Insurance start date:** __________	**Are you covered under any other medical plan?** ☐ Yes – Provide carrier &policy #: ☐ No

Spouse Name (Last, First, MI)	**Spouse SSN**	**Spouse Date of Birth**	**Spouse Sex** ☐ Female ☐ Male
Is your spouse covered under any other medical plan? If yes, provide carrier & policy number:			
Dependent Child #1 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male
Is this child covered under any other medical plan? If yes provide carrier and policy number :			
Dependent Child #2 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male
Is this child covered under any other medical plan? If yes provide carrier and policy number :			
Dependent Child #3 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male
Is this child covered under any other medical plan? If yes – please provide carrier and policy number :			

PRE TAX OPTION – SIGNATURE REQUIRED FOR PREMIUMS PAID BEFORE TAXES

I understand that I am allowed to use flexible pay for the purpose of qualified benefits as part of a flexible benefits plan under Section 125 of the Internal Revenue Code. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the health coverage shown above. Such reductions, considered as elective contributions under the plan, shall commence with my first paycheck following the effective enrollment date. I further authorize future adjustments in the amount of the salary reduction in the event that the cost of coverage is changed during the plan year. I also understand that the purpose of this program is to allow employees to select this qualified benefit within the guidelines of the Internal Revenue Code. I also understand that this election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are in conjunction with a qualifying event, e.g.; marriage, divorce, death of a spouse or child, birth or adoption of a child and termination of employment of a spouse

Signature of Employee: ____ **Date Signed:**_____________

AUTHORIZATION FOR INSURANCE COVERAGE – SIGNATURE REQUIRED

I hereby apply for self-funded and/or insurance coverage. I agree the copy of my signature or copy of this form may be accepted as my signature. I authorize necessary deductions from my salary, account or dues for any contributions required. I acknowledge that the Privacy Standards of the Health insurance Portability and Accountability Act Regulations authorize the use and disclosure of Protected Health information for Treatment, Payment and Health Care Operations purposes without the member's written consent. I agree that to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage, by any underwriter or carrier. Subject to the approval of this application, the coverage applied for shall become effective in accordance with the terms of the plan document. I understand that I must meet all eligibility requirements before coverage can become effective. I understand that any falsification will result in denial or cancellation of coverage so that the result is no coverage as ever in effect any claims paid will be reimbursed by me. I acknowledge receipt of the summary plan description. I received and read a copy of the Notice of Pre-Existing Condition Exclusions and Special Enrollment Rights at or before the time I was initially offered enrollment in the health plan.

Signature of Employee: ____ **Date Signed:** _____________

HOG SLAT PAID LIFE INSURANCE POLICY

This health insurance policy comes with a free $10,000 life insurance policy. Please indicate below who you would like to be the beneficiary of this policy:

Primary Beneficiary Name: ________________________________ **Relationship:** ____________________

Secondary Beneficiary Name: ______________________________ **Relationship:** ____________________