

WNCCUMC 2017 OPEN ENROLLMENT



Please return to Treasury Services office by January 1, 2017.

EMPLOYEE NAME AND ADDRESS:		A phone number is required:	
		Home: _____ Office: _____	
CURRENT COVERAGE:		ELECTION: (MARK COVERAGE ELECTION BELOW)	
Group number: 283F or 283 (Circle one) Effective Date: January 1, 2017 Current Coverage: NA		Coverage Tier: <input type="checkbox"/> Single <input type="checkbox"/> Emp + Spouse <input type="checkbox"/> Emp + Children <input type="checkbox"/> Emp + Family	Plan: <input type="checkbox"/> Basic (Plan 3 – 283F) <input type="checkbox"/> Basic Plus (Plan 1 - 283)

NAME	REL	GENDER	SSN*	BIRTH DATE	EFFECTIVE DATE	HAS OTHER INSURANCE
Information about you:						
_____	EMP	___	_____	_____	01/01/2017	<input type="checkbox"/>
Your dependents:						
_____	_____	___	_____	_____	_____	<input type="checkbox"/>
_____	_____	___	_____	_____	_____	<input type="checkbox"/>
_____	_____	___	_____	_____	_____	<input type="checkbox"/>

***Dependent SSNs are required under provisions of the Affordable Care Act (ACA)**

Are you declining enrollment for yourself or your dependent because you or your dependents have coverage under another health plan? **YES** **NO**

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents, (including your spouse) because of other health benefit plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee and will be subject to an eighteen (18) month waiting period before coverage can begin. In addition if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Additionally, enrollment plan changes can be made due to a change in your ministerial appointment.

Release of Medical Information

By signing this form, I authorize my physician, medical professional, hospital, clinic, or other medically related facility insurance company or other organization, institution or person, that has any records or knowledge of me or my health, or my dependents or their health, to give such information to Healthgram, Inc., if requested.

The terms of the plan have been explained to me and I have a complete understanding of my rights and responsibilities under the Plan. I hereby authorize my employer to make payroll deductions for the premium required for participation in the Plan (s) or their authorized representatives I affirm that the information is correct.

EMPLOYEE SIGNATURE

DATE