Benefits Election/Change Form – Maui Active

Check The Appropriate Box

☐ Initial Enrollment ☐ Open Enrollment
☐ Marriage ___ ___ / ___ ___ / ___ ___
☐ Birth / Adoption ___ ___ / ___ ___ / ___ ___
☐ Employment Status Change ___ ___ / ___ ___ / ___ ___
☐ Special Enrollment ___ ___ / ___ ___ / ___ ___
☐ Cancel Coverage
☐ Other ___________________

Employee Information

Last Name	First Name	Initial	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Location: Maui			
Physical Street Address	City	State	Zip Code
Mailing Street Address	City	State	Zip Code
Home Telephone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Work Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Email Address	

Date of Birth	Date of Hire	Effective Date	Marital Status	Sex
___ ___ / ___ ___ / ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___		

Benefit Elections

Full-Time Employees Refer to the Benefits Guide for Rates	HMSA Medical		Kaiser Medical		HMSA Dental		UHC Vision
Tier	HMO	PPP	HMO	POS	DHMO	DPPO	PVRC# 0001
	Policy #72764-1		Policy #4595		Policy #72764-1		Policy #718181
Employee Only	☐	☐	☐	☐	☐	☐	☐
Employee + Spouse (One Dependent)	☐	☐	☐	☐	☐	☐	☐
Employee + Family	☐	☐	☐	☐	☐	☐	☐
	Waive Medical ☐				Waive Dental ☐		Waive Vision ☐

Reason for Waiving Coverage:

Please complete for each of your eligible dependents

Check Appropriate Box	First Name, Initial, Last Name / Social Security Number	Sex	Date of Birth	Relationship Type	Coverage Elected
☐ Enroll ☐ Cancel ☐ Change	SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ / ___ ___ / ___ ___	☐ Spouse ☐ Domestic Partner	Med ☐ Den ☐ Vis ☐

Eligible dependent coverage up to age 26 for Medical, Dental and Vision Coverage

Check Appropriate Box	First Name, Initial, Last Name / Social Security Number	Sex	Date of Birth	Relationship Type	Coverage Elected
☐ Enroll ☐ Cancel ☐ Change	SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ / ___ ___ / ___ ___		Med ☐ Den ☐ Vis ☐
☐ Enroll ☐ Cancel ☐ Change	SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ / ___ ___ / ___ ___		Med ☐ Den ☐ Vis ☐
☐ Enroll ☐ Cancel ☐ Change	SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ / ___ ___ / ___ ___		Med ☐ Den ☐ Vis ☐
☐ Enroll ☐ Cancel ☐ Change	SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ / ___ ___ / ___ ___		Med ☐ Den ☐ Vis ☐
☐ Enroll ☐ Cancel ☐ Change	SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ / ___ ___ / ___ ___		Med ☐ Den ☐ Vis ☐

Other Coverage Information

On the day coverage begins will you or any of your eligible dependents be covered by any other insurance?
☐ Yes ☐ No If yes, please complete the information below. Use an additional sheet if more than one additional policy will be in force.

Coverage Type	Insurance Company Name	Phone Number	Group Number	Policy Number
☐ Medical / Medicare ☐ Dental ☐ Vision		(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___		

Policy Coverage Dates	Policy Holder Name	Social Security Number
_____ to _____		___ ___ ___ - ___ ___ - ___ ___ ___ ___

Family Members Covered	Medicare Card Number	Effective Date
_____ _____ _____ _____		Part A: ___ ___ / ___ ___ / ___ ___ Part B: ___ ___ / ___ ___ / ___ ___

Flexible Spending Account Elections

If enrolling, fill in your election below and complete the HealthSmart Enrollment Form

Healthcare Spending Account

The amount you elect will be deducted in equal payments for the remainder of the calendar year.

Minimum Election: $100 / Maximum Election: $2,650
Annual Election: $_____ Per Pay (_____) Deduction $_____

Dependent Care Spending Account

Minimum Election: $100 / Maximum Election: $5,000 or $2,500 (married filing seperately)
Annual Election: $_____ Per Pay (_____) Deduction $_____

Voluntary Life and AD&D Insurance Elections

If enrolling, fill in your election below and complete the CIGNA Voluntary Life Application if you elect over the Guarantee Issue Amount

If you enroll within 31 days of your initial eligility, you are eligibile to elect up to the Guarantee Issue amount without providing evidence of good health. If you did not enroll for Voluntary Life within 31 days of your initial eligibility, you will need to provide evidence of good health in order to enroll.

During Open Enrollment, if you are currently enrolled for Voluntary Life under the Guarantee Issue Amount, you may increase your current amount by $10,000 not to exceed Guarantee Issue without providing evidence of good health.

Coverage Type	Supplemental Life Amount Elected	Supplemental AD&D Amount Elected	No Change	Waive
Employee Coverage	$_____	$_____	☐	☐
Dependent Spouse Coverage	$_____	$_____	☐	☐
Dependent Child(ren) Coverage	$_____	N/A	☐	☐

Voluntary Worksite Benefits Elections

Accidental Injury Insurance	Critical Illness Insurance		Hospital Care Indemnity Insurance
☐ Enroll ☐ Waive	☐ Enroll ☐ Waive		☐ Enroll ☐ Waive
☐ Employee Only	Benefit Amount (Select One)	Select Tier	☐ Employee Only
☐ Employee + Spouse	☐ $5,000	☐ Employee Only	☐ Employee + Spouse
☐ Employee + Child(ren)	☐ $10,000	☐ Employee + Spouse	☐ Employee + Child(ren)
☐ Employee + Family	☐ $20,000	☐ Employee + Child(ren)	☐ Employee + Family
		☐ Employee + Family	
	Have you or a dependent to be enrolled in the 5K, 10K, or 20K Voluntary Critical Illness Insurance plan used Tobacco products in the last 12 months? ☐ Yes ☐ No		

Certification and Authorization

I certify that all information on this form is true and complete to the best of my knowledge.

I understand that my Medical, Dental and Vision premiums and my Flexible Spending Account contributions will be deducted Pre-Tax.

- I may benefit from a decrease in my tax liability, however my payments into the Social Security System and my benefits under Social Security may also be reduced;
- During the course of the Plan Year (1/1/19 to 12/31/19), I may not increase, decrease, or eliminate any pre-tax payroll-deducted premiums unless I experience a related "change in status". Examples include marriage, divorce, death of spouse or child, birth or adoption of a child, loss of other coverage, or termination of your spouse's employment.

If you would prefer Post-Tax deductions please see Human Resources.

I understand that for Life and AD&D Insurance I must be actively at work in order for coverage to take effect and that coverage must be approved by CIGNA.

I authorize deductions for the required contributions from my earnings.

EMPLOYEE SIGNATURE:	DATE: