



Section Must Be Completed By Owner

Effective Date	
Franchise Owner	
Franchise Owner Email	

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Hire Date: _____	<input type="checkbox"/> Change in Status Date: _____	<input type="checkbox"/> ACA Full-Time Date: _____	<input type="checkbox"/> Court Order
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SECTION A: Personal Information (Please Print Clearly)

Name (Last, First, MI)		Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Social Security #	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City, State, Zip		Phone	
Date of Hire	Job Title	Annual Salary	Email Address		

SECTION B: Employee / Dependent Information

Name (Last, First, MI) <i>Please Print Clearly</i>	Social Security #	Date of Birth	Plan Elections - Please <input checked="" type="checkbox"/> appropriate coverage & Tier
<input type="checkbox"/> M <input type="checkbox"/> F Employee			<input type="checkbox"/> Medical – Aetna <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Dental – Sunlife <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life – Employee Amt \$ _____
<input type="checkbox"/> M <input type="checkbox"/> F Spouse			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life – Spouse Amt \$ _____
<input type="checkbox"/> M <input type="checkbox"/> F Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life – Child Amt \$ _____
<input type="checkbox"/> M <input type="checkbox"/> F Child			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Vol. Life – Child Amt \$ _____

SECTION C: Ancillary Rates (Monthly Costs)

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family		
Plan A – Dental – High PPO	\$49.75 <input type="checkbox"/>	\$100.83 <input type="checkbox"/>	\$116.44 <input type="checkbox"/>	\$167.53 <input type="checkbox"/>	Waive Dental <input type="checkbox"/>	No Changes <input type="checkbox"/>
Plan B – Dental – Low PPO	\$30.61 <input type="checkbox"/>	\$62.34 <input type="checkbox"/>	\$72.53 <input type="checkbox"/>	\$104.27 <input type="checkbox"/>		
Plan C – Dental – DHMO (TX ONLY)	\$17.24 <input type="checkbox"/>	\$26.45 <input type="checkbox"/>	\$34.09 <input type="checkbox"/>	\$44.38 <input type="checkbox"/>		
Plan D – Dental – DHMO (CA ONLY)	\$15.88 <input type="checkbox"/>	\$25.29 <input type="checkbox"/>	\$33.51 <input type="checkbox"/>	\$38.84 <input type="checkbox"/>	Waive Vision <input type="checkbox"/>	No Changes <input type="checkbox"/>
Vision – VSP	\$9.23 <input type="checkbox"/>	\$18.46 <input type="checkbox"/>	\$20.29 <input type="checkbox"/>	\$29.51 <input type="checkbox"/>		

SECTION D: Medical Rates (Monthly Costs)

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family		
Plan A – Aetna 80/50 \$1,500 Deductible	\$817.61 <input type="checkbox"/>	\$1,716.90 <input type="checkbox"/>	\$1,553.34 <input type="checkbox"/>	\$2,453.61 <input type="checkbox"/>	Waive Medical <input type="checkbox"/>	No Changes <input type="checkbox"/>
Plan B – Aetna 80/50 \$3,500 Deductible	\$727.61 <input type="checkbox"/>	\$1,527.90 <input type="checkbox"/>	\$1,382.35 <input type="checkbox"/>	\$2,183.52 <input type="checkbox"/>		
Plan C – Aetna 70/50 \$5,000 Deductible	\$611.47 <input type="checkbox"/>	\$1,284.02 <input type="checkbox"/>	\$1,161.71 <input type="checkbox"/>	\$1,835.01 <input type="checkbox"/>		
Plan D – Aetna HMO \$3,000 Deductible (CA Only)	\$734.14 <input type="checkbox"/>	\$1,541.58 <input type="checkbox"/>	\$1,394.75 <input type="checkbox"/>	\$2,203.10 <input type="checkbox"/>		

SECTION E: Other Insurance Coverage (If YES, please complete this section and sign in Section I.)

Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes (attach proof of other coverage)
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SECTION F: Voluntary Life and AD&D

<input type="checkbox"/> Employee Life _____ (Guarantee Issue = \$130,000)	<input type="checkbox"/> Monthly Premium \$ _____	Waive Voluntary Life <input type="checkbox"/>	No Changes <input type="checkbox"/>
<input type="checkbox"/> Spouse Life _____ (Guarantee Issue = \$50,000)	<input type="checkbox"/> Monthly Premium \$ _____		
<input type="checkbox"/> Child Life _____ (Guarantee Issue = \$50,000)	<input type="checkbox"/> Monthly Premium \$ _____		

Age Band	Employee Rate Per \$1,000 of Coverage (Monthly)	Spouse Rate Per \$1,000 of Coverage (Monthly)
Under 20	\$0.078	\$0.078
20 – 24	\$0.104	\$0.078
25 – 29	\$0.104	\$0.104
30 – 34	\$0.130	\$0.130
35 – 39	\$0.182	\$0.130
40 – 44	\$0.234	\$0.182
45 – 49	\$0.390	\$0.260
50 – 54	\$0.702	\$0.468
55 – 59	\$1.222	\$0.832
60 – 64	\$1.872	\$1.144
65 – 69	\$3.016	\$2.002
70 – 74	\$4.498	\$2.964
75+	\$8.918	\$5.954
Child Voluntary Life and AD&D		\$0.208

SECTION G: Beneficiaries

Name	Relationship	Primary	Contingent	Percentage	Employer-Paid Life	Voluntary Life
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

SECTION H: EMPLOYER TO COMPLETE – Employer-Paid Life Insurance

<input type="checkbox"/> \$100,000 - \$28.00/month	<input type="checkbox"/> \$50,000 - \$14.00/month	<input type="checkbox"/> \$10,000 - \$2.80/month	<input type="checkbox"/> Not Offered
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Employer Contribution: _____

SECTION I: Declination of Coverage

I understand that my company has offered me healthcare coverage that is deemed affordable and compliant according to the Affordable Care Act, and I decline to participate in the plan at this time. I understand that I may be subject to an individual tax of 2.5% of household income, unless I obtain permitted coverage elsewhere. I understand that if I decide to enroll at a later date, I will have to wait until the next Open Enrollment period, unless I experience an allowable Qualified Event, as defined by the Internal Revenue Code (IRC).

Declination of Coverage Signature: _____

SECTION J: EMPLOYEE SIGNATURE

I elect coverage as indicated above and consent to all terms and conditions stated above. Furthermore, I declare that the information represented above is true and correct. If contributions are required for Healthcare coverage, I authorize my employer to deduct such contributions from earnings via payroll deduction until further notice. I understand that these deductions will be made on a pre-tax basis. My participation in the plan is subject to all the plan terms and conditions as set forth in the plan documents and Summary Plan Description. I understand that I cannot change my elections until the next Open Enrollment period, unless there is a "qualified" change in status.

Signature: _____

Date: _____

Please submit form to: **Grant McClory**, Account Manager, Benefits Exchange Alliance

Email: gmccclory@bxall.com

Fax: (949)297-2684

Phone: (949)900-9534

