2020 – 2021 Plan Year

BXA Benefits Exchange Alliance

PtnProTradeNet

Section Must Be Completed By Owner	
Effective Date	
Franchise Owner	
Franchise Owner Email	

☐ Open Enrollment	☐ New Hire	☐ Re-Hire Date: _____	☐ Change in Status/QE Date: _____	☐ ACA Full-Time Date: _____	☐ Court Order

SECTION A: Personal Information (Please Print Clearly)

Name (Last, First, MI)	Date of Birth	Marital Status ☐ Single ☐ Married	Social Security #	Gender ☐ M ☐ 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) *Please Print Clearly*	Social Security #	Date of Birth	Plan Elections - Please √ appropriate coverage & Tier
	Employee			☐ Medical – Aetna ☐ A ☐ B ☐ C ☐ D ☐ Dental – Sunlife ☐ A ☐ B ☐ C ☐ D ☐ Vision ☐ Vol. Life – Employee Amt $ _____
☐ M ☐ F	Spouse			☐ Medical ☐ Dental ☐ Vision ☐ Vol. Life – Spouse Amt $ _____
☐ M ☐ F	Child			☐ Medical ☐ Dental ☐ Vision ☐ Vol. Life – Child Amt $ _____
☐ M ☐ F	Child			☐ Medical ☐ Dental ☐ Vision ☐ 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 ☐	$100.83 ☐	$116.44 ☐	$167.53 ☐	Waive Dental ☐	No Changes ☐
Plan B – Dental – Low PPO	$30.61 ☐	$62.34 ☐	$72.53 ☐	$104.27 ☐		
Plan C – Dental – DHMO (TX ONLY)	$17.24 ☐	$26.45 ☐	$34.09 ☐	$44.38 ☐	Waive Vision ☐	No Changes ☐
Plan D – Dental – DHMO (CA ONLY)	$15.88 ☐	$25.29 ☐	$33.51☐	$38.84 ☐		
Vision – VSP	$9.23 ☐	$18.46 ☐	$20.29 ☐	$29.51 ☐		

SECTION D: Medical Rates (Monthly Costs)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family		
Plan A – Aetna 80/50 $1,500 Deductible	$1,144.57 ■	$2,403.47 ☐	$2,174.50 ☐	$3,434.78 ☐	Waive Medical ☐	No Changes ☐
Plan B – Aetna 80/50 $3,500 Deductible	$991.35 ☐	$2,081.75 ☐	$1,883.43 ☐	$2,975.01 ☐		
Plan C – Aetna 70/50 $5,000 Deductible	$721.69 ☐	$1,515.47 ☐	$1,371.11 ☐	$2,165.78 ☐		
Plan D – Aetna HMO $3,000 Deductible (CA Only)	$1,088.75 ☐	$2,286.21 ☐	$2,068.46 ☐	$3,267.26 ☐		

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

Medicare Eligible ☐ Yes ☐ No	**Other Coverage** ☐ No ☐ Yes (attach proof of other coverage)

SECTION F: Voluntary Life and AD&D

☐ Employee Life _____ (Guarantee Issue = $130,000 or 3x annual salary, whichever is less)	☐ Monthly Premium $_____	Waive Voluntary Life ☐	No Changes ☐
☐ Spouse Life _____ (Guarantee Issue = $50,000, up to half the employee election)	☐ Monthly Premium $_____		
☐ Child Life _____ (Guarantee Issue = $10,000)	☐ 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
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐

SECTION H: EMPLOYER TO COMPLETE Employer Paid Life Insurance

☐ $100,000 - $28.00/month	☐ $50,000 - $14.00/month	☐ $10,000 - $2.80/month	

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: **Aundrea Roe**, Account Manager, Benefits Exchange Alliance
Email: aroe@bxall.com
Fax: (949)575-6785
Phone: (949)575-6784

BXA