



# Enrollment Designation Form

## 1. DESIGNATE ACTION OCTOBER 1, 2020 PLAN YEAR (check all that apply)

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> Adding Spouse
<input type="checkbox"/> New Hire	<input type="checkbox"/> Address/Phone Change	<input type="checkbox"/> Dropping Spouse
<input type="checkbox"/> Qualifying Event (Reason):	<input type="checkbox"/> Name Change	<input type="checkbox"/> Adding Dependent
Date ____/____/____		<input type="checkbox"/> Dropping Dependent

## 2. PERSONAL INFORMATION (please print clearly)

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY # - - -	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
HOME STREET ADDRESS	APT.	CITY	STATE	ZIP
DATE OF BIRTH: ____/____/____	HOME PHONE: ( ) -	MARITAL STATUS:	POSITION:	FULL TIME DATE OF HIRE: ____/____/____
CURRENT ACTIVE EMPLOYMENT TYPE: <input type="checkbox"/> Full-Time Employee <input type="checkbox"/> Part-Time Employee				EFFECTIVE DATE:

## 3. ENROLLMENT & WEEKLY CONTRIBUTION INFORMATION (select the appropriate plan and coverage level only if you are changing coverage)

MEDICAL, RX, DENTAL, and VISION are bundled together (Rates are weekly without wellness discount)

<b>I ELECT TO:</b> <input type="checkbox"/> Enroll In <input type="checkbox"/> Change <input type="checkbox"/> Cancel	<b>PPO</b> Employee Only <input type="checkbox"/> 104.20 Employee + Spouse <input type="checkbox"/> 250.61 Employee + Child <input type="checkbox"/> 174.61 Employee + Children <input type="checkbox"/> 268.51 Employee + Family <input type="checkbox"/> 321.87	<b>QHDHP w. HSA</b> Employee Only <input type="checkbox"/> \$64.30 Employee + Spouse <input type="checkbox"/> \$141.76 Employee + Child <input type="checkbox"/> \$107.75 Employee + Children <input type="checkbox"/> \$165.69 Employee + Family <input type="checkbox"/> \$182.07
<b>I AM WAIVING coverage:</b> <input type="checkbox"/> I certify that available benefits have been explained in detail.		

## 4. DEPENDENT INFORMATION (Provide all the following information about your eligible family members that you want to enroll or decline coverage for. Use a separate sheet of paper to add more dependents.)

Relationship	Date of Birth	Name (Last, First, MI)	Social Security #	Handi-capped	Medical, Dental, and Vision
Spouse: <input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____		____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____		____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____		____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____		____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	____/____/____		____-____-____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Drop

5. ADDITIONAL HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION

<b>2020 Total Max Contribution:</b> \$3,550 Individual \$7,100 Family	<b>AIS Contribution:</b> \$250 Individual \$500 Family
	<b>2020 Employee Max Contribution*:</b> \$3,300 Individual \$6,600 Family
	*Additional Catch-up: \$1,000 if 55 or older
Annual: \$ _____	
Per Pay: \$ _____ (Divide annual by 52 pays)	
<b>2021 Total Max Contribution:</b> \$3,600 Individual \$7,200 Family	

**AUTHORIZATION AND SIGNATURE**

*I hereby authorize automatic deductions from my paycheck of the premium payments associated with the above enrollments. I agree that I am solely responsible for the premium payments associated with the enrollment, whether these premium payments are paid through payroll deduction or are self-paid. I agree that any missed premiums payments, including those missed through administrative error or non-issuance of a paycheck, will be reimbursed by me to AIS.* Premium contributions will continue to be deducted from your pay on a pre-tax basis for coverage that you elect in each future year. I hereby authorize my providers of health care to disclose information from my medical records to the extent necessary to allow responsibility for claim payment to be determined, for payment to be made and/or for utilization review and quality assurance purposed. My signature below is my acknowledgement that I have read this entire document and these are my enrollment choices.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_