Enrollment Designation Form

ADVANCED INDUSTRIAL SERVICES, INC.

1. DESIGNATE ACTION OCTOBER 1, 2021 PLAN YEAR (check all that apply)

☐ Open Enrollment	☐ Terminate Coverage	☐ Adding Spouse
☐ New Hire	☐ Address/Phone Change	☐ Dropping Spouse
☐ Qualifying Event (Reason):	☐ Name Change	☐ Adding Dependent
Date_____/_____/_____		☐ Dropping Dependent

2. PERSONAL INFORMATION (please print clearly)

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	SEX
			- -	☐ Male ☐ 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:	EFFECTIVE DATE:
☐ Full-Time Employee ☐ Part-Time Employee	

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)

I ELECT TO:	PPO		QHDHP w. HSA	
☐ Enroll In	Employee Only	☐ 104.20	Employee Only	☐ $64.30
☐ Change	Employee + Spouse	☐ 250.61	Employee + Spouse	☐ $141.76
☐ Cancel	Employee + Child	☐ 174.61	Employee + Child	☐ $107.75
	Employee + Children	☐ 268.51	Employee + Children	☐ $165.69
	Employee + Family	☐ 321.87	Employee + Family	☐ $182.07

I AM WAIVING coverage:

☐ 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: ☐ Male ☐ Female	___/___/____		_____-____-_____	☐ Yes ☐ No	☐ Add ☐ Drop
☐ Son ☐ Daughter	___/___/____		_____-____-_____	☐ Yes ☐ No	☐ Add ☐ Drop
☐ Son ☐ Daughter	___/___/____		_____-____-_____	☐ Yes ☐ No	☐ Add ☐ Drop
☐ Son ☐ Daughter	___/___/____		_____-____-_____	☐ Yes ☐ No	☐ Add ☐ Drop
☐ Son ☐ Daughter	___/___/____		_____-____-_____	☐ Yes ☐ No	☐ Add ☐ Drop

SIGNATURE & ADDITIONAL INFORMATION REQUIRED ON REVERSE SIDE

5. ADDITIONAL HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION

2021 Total Max Contribution: $3,600Individual
$7,200 Family

AIS Contribution: $250 Individual
$500 Family

2020 Employee Max Contribution*:$3,350 Individual
$6,700 Family

*Additional Catch-up: $1,000 if 55 or older

Annual: $_____

Per Pay: $_____ (Divide annual by 52 pays)

2022 Total Max Contribution: $3,650 Individual
$7,300 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: _____