Valley Catholic Early Learning School

2022 Benefit Enrollment/Waiver Form

COVERAGE EFFECTIVE DATE:
1/1/2022

EMPLOYEE INFORMATION

Name: (First)	(Last)	Social Security Number:	Gender: ☐ Male ☐ Female
Address:		City/State/Zip:	Home/Cell Phone:
Date of Birth:	Original Date of Hire: / Full-time Date of Hire:	E-mail Address:	Marital Status: ☐ Single ☐ Married ☐ DP

EMERGENCY CONTACT

Name:	Relationship:	Phone:	City & State:

I wish to make NO benefit changes to my current elections ☐ Initial _____ Please sign the back of this form.

Please enter your benefit elections below (list covered family members on the reverse side of this form):

Medical/Rx: ***Kaiser Permanente of Oregon*** ***Employee costs are shown as monthly rates.*** ☐ Enroll ☐ Waive	***Base HMO***	☐ Employee Only **$0.00** ☐ Employee + Child(ren) **$514.81**	☐ Employee + Spouse **$605.66** ☐ Employee + Family **$1,120.47**
	☐ I am waiving.	I have other medical coverage with _____	
Dental: ***Employee costs are shown as monthly rates.*** ☐ Enroll ☐ Waive	***Willamette Dental***	☐ Employee Only **$0.00** ☐ Employee + Child(ren) **$87.30**	☐ Employee + Spouse **$66.30** ☐ Employee + Family **$153.70**
	The Standard	☐ Employee Only **$0.00** ☐ Employee + Child(ren) **$76.56**	☐ Employee + Spouse **$58.12** ☐ Employee + Family **$134.68**
Flexible Spending Account: **WEX, Inc** ***Election will be funded via payroll deductions.*** ☐ Enroll ☐ Waive	**Healthcare FSA Maximum Election: $2,850** ($237.50 per paycheck) **Dependent Care (daycare) Maximum Election: $5,000** ($416.66 per paycheck) **Healthcare FSA**: I elect to contribute $ _____ **Per paycheck** for the 2022 plan year. **Dependent Care FSA:** I elect to contribute $ _____ **Per paycheck** for the 2022 plan year. PLEASE SEE DISCOVERY BENEFITS, INC BENEFIT MATERIALS FOR IMPORTANT INFORMATION BEFORE ENROLLING		
Voluntary Life/AD&D: **Prudential**	**I wish to purchase additional Life Insurance for ☐ Myself, ☐ Spouse/DP, and/or ☐ Child(ren)** ***(See HR for additional enrollment information)*** *Example:30-year old purchasing $100,000 =* ***$5.75*** *per paycheck*		

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VALLEY CATHOLIC EARLY LEARNING SCHOOL

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☐ Enroll ☐ Waive	

Beneficiary Designation	Full Name	Relationship	Address
Contingent*			

Enrollment type	Desired Coverage Amount	Monthly Premium	Date of marriage is required for spouse coverage
Employee only			
Spouse			
Child(ren)			

*Contingent incase primary beneficiary is no longer surviving.

List all eligible dependents (i.e. spouse and/or children up to age 26) who are to be enrolled for benefits.

PLEASE NOTE! YOU MUST PROVIDE A VALID SOCIAL SECURITY NUMBER FOR EACH DEPENDENT TO BE COVERED BY INSURANCE

Dependent's Full Name	Relationship to the Employee	Social Security Number	Date of Birth	Gender	Please Enroll in Insurance
					☐ Medical ☐ Dental ☐ Vol Life/AD&D
					☐ Medical ☐ Dental ☐ Vol Life/AD&D
					☐ Medical ☐ Dental ☐ Vol Life/AD&D

By my signature below, I verify that all of the above information is true and correct to the best of my knowledge. I authorize the above elections and any required payroll deductions. I authorize any insurance company or health care provider to furnish the insurance carrier with any and all records pertaining to the health coverage of those I have listed above for the purpose of adjudicating claims. I understand that if I waive coverage for myself and/or any of my eligible dependents, I and/or they will be ineligible to obtain coverage under the Maryville Nursing Home Plans until the next Open Enrollment period unless I experience a "qualifying event," such as marriage, divorce, birth/adoption of a child, or loss of other coverage in which case enrollment must be requested within 30 days of the qualifying event. I understand that I cannot add or change the benefits I have elected until the next Open Enrollment period in 2022 to be effective January 1, 2023 unless I have a qualifying event, such as a change in family or employment status. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. NOTE: If you decline enrollment for yourself and/or your dependents (including Spouse/Domestic Partner) due to being covered under other health insurance coverage, in the future you may be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days of termination of other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents.

Applicant's Signature: _____

Date: _____

RCW 48.135.080, "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."