

2012 Advisors Forum Annual Enrollment Form

1. Employee Information				
Last Name:		First Name:		MI:
Address:		City:	St:	Zip:
Date of Birth:	Social Security Number:	Phone:	Coverage Effective Date:	
Position:	Annual Salary \$	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time Hours/Wk	Gender:	
Email Address:			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)d		Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have coverage elsewhere (such as your spouse's employer)? <input type="checkbox"/> Yes (complete box 9) <input type="checkbox"/> No	

2. Medical

IMPORTANT: All new participants must complete this section and include a copy of your insurance card from you previous provider.

Prior Coverage Information	Begin Date:	End Date:	Provider Name
Coverage Option	Plan A - Lower Deductible	Plan B - HSA	Plan C - HSA
Member Only	<input type="checkbox"/> \$ 709.46	<input type="checkbox"/> \$ 562.10	<input type="checkbox"/> \$ 701.89
Member + Spouse	<input type="checkbox"/> \$ 1,418.92	<input type="checkbox"/> \$ 1,124.20	<input type="checkbox"/> \$ 1,295.78
Member + Child(ren)	<input type="checkbox"/> \$ 1,347.97	<input type="checkbox"/> \$ 1,068.00	<input type="checkbox"/> \$ 1,231.00
Member + Family	<input type="checkbox"/> \$ 2,128.37	<input type="checkbox"/> \$ 1,684.28	<input type="checkbox"/> \$ 1,941.35
<input type="checkbox"/> I decline to participate in the Medical Plan			

3. Dental

Choose One	<input checked="" type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/> Employee & Family
<input type="checkbox"/> Dental Plan- Plan A <input type="checkbox"/> Waive Coverage	\$46.42	\$92.83	\$88.18	\$139.51

4. Vision

Choose One	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & One	<input type="checkbox"/> Employee & Family
<input type="checkbox"/> Vision Plan <input type="checkbox"/> Waive Coverage	\$11.20	\$14.20	23.58

5. Life Insurance/Accidental Death & Dismemberment

(Salary equals amount entered on page one) If life amount is greater than \$ 375,000– Evidence of Insurability form is required)

1. <input type="checkbox"/> Employee Life/AD&D (\$0.21/1000)	<input type="checkbox"/> 1 X Salary	<input type="checkbox"/> 2 X Salary	<input type="checkbox"/> 3 X Salary
2. <input type="checkbox"/> Spouse Life* (\$0.21/1000.)	<input type="checkbox"/> \$10,000 (\$2.10/mo)	<input type="checkbox"/> \$25,000 (\$5.25/mo.)*	*EOI Question Req'd
3. <input type="checkbox"/> Child life (\$0.61/mo.)	<input type="checkbox"/> \$5,000 (\$.85/mo)		
4. <input type="checkbox"/> Waive Life Insurance			

*Answer if Electing \$25,000 or more Spouse life: In the last 6 months, have you or any of your dependents received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer; any condition related to Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex; or any other life threatening condition? Spouse Yes No

AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY DEPENDENT WITH A "YES" ANSWER TO THE ABOVE QUESTION.

6. Disability (Salary must equal amount entered on page one) Note: EOI required if increasing coverage

1. <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Waive	(Enter Salary Amount) \$	<ul style="list-style-type: none"> Benefit equals 60% of weekly salary up to a \$2,500 benefit. Rate is \$0.26 per \$10 of weekly benefit covered.
2. <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waive	(Enter Salary Amount) \$	<ul style="list-style-type: none"> Benefit equals 60% up to a \$10,000 maximum monthly benefit) Rate is \$0.50 per \$100 of monthly covered payroll

IMPORTANT: Complete both sides of this form

7. List All Eligible Family Members Enrolled For Medical, Dental, Vision, Optional Dependent Life

Name (Last, First, MI):	Gender M F	Birth Date (Mo./Day/Yr.)	Social Security #.	Relationship

8. Mid-Year Change Information

To add or delete dependents or make a plan change mid year, (1) check the qualifying event allowing the change and (2) indicate the date of the event below: **Event allowing dependent addition and some plan changes** (event must have been within the last 31 days): *The change in election must be consistent with the event.*

Marriage Birth of child Court-ordered custody/support/legal guardianship Adoption/Pre-adoptive placement.

(If dependent has or had other coverage within last 63 days, provide Certificate of Creditable Coverage.)

Dependent lost eligibility for other coverage due to, specify:

The Date of Event is the last date of the other coverage:

Event allowing/requiring dependent deletion and some plan changes: *The change in election must be consistent with the event.*

(Notify Amy Ahrens when a covered dependent loses eligibility (within no more than 30 days). Notice for COBRA continuation within 60 days.

Death of Dependent Divorce/legal separation Change in support order Other loss of dependent status due to, specify:

The Date of Event is the last date of the other coverage:

9. Information About Other Group Coverage

Are you, your spouse or any dependents continuing coverage by another plan? *(Please include anyone eligible for Medicare/Medicaid.)*

Yes No If yes, complete below:

Name (Last, First, MI):	Medical	Dental	Other Employer	Name and Number of Plan
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

10. List Your Beneficiaries For Life and AD&D Insurance

Primary (Last/First/MI):

Relationship:

Contingent (Last/First/MI):

Relationship:

If more than one primary or contingent beneficiary is to be specified, attach beneficiary information on a separate page. Unless otherwise specified, payment will be shared equally by all primary beneficiaries who survive the Insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise stated. If you are married, but choose someone other than your spouse as beneficiary, have your spouse sign below to acknowledge the other beneficiary.

Spouse's Signature:

Date:

11. Authorization

I have been given the opportunity to enroll in Wealth Advisor Benefit Plan. I authorize Wealth Advisor Benefit Plan to make any necessary deductions from my pay for elected coverages. Medical, and dental and other health and disability deductions will be deducted pre-tax from my pay unless I contact Human Resources to indicate a different election. I understand that I cannot change my benefit enrollment elections until the next open enrollment period unless I have a qualified change in status (which must be reported to Human Resources within 31 days of the event). I authorize payment of medical benefits to preferred providers where applicable, for those charges covered by my group insurance benefits. I authorize release, for the term of my coverage, to or by my physician or health care provider of any medical information including copies of medical records, or insurance carrier with information necessary to establish student eligibility. This authorization will remain valid during my term of coverage under my group insurance plan or 12 months, whichever is less. I or my authorized representative may request a copy of this authorization and a photocopy of this authorization will be considered valid.

Employee Signature (typed name serves as signature)

Date

Forms may be submitted by clicking blue button:

Please remember in addition to your monthly premium there is an initial enrollment fee of \$350/participant as well as a \$13/mo/participant administration fee. Thereafter an annual fee of \$350 will be charged in addition to the monthly fee.