

2010 Benefit Election Form

1. PERSONAL INFORMATION

Last Name:		First Name:		MI:	
Address:			City:	State:	Zip:
Date of Birth:	Social Security Number:		Phone:	Effective Date:	
Position:		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time Hours/Wk		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Email Address:		Salary:\$			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your children older than age 16? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, you must provide proof of full time student status	Do you have coverage elsewhere (such as your spouse's employer)? <input type="checkbox"/> Yes (complete box 6) <input type="checkbox"/> No	

2. MEDICAL COVERAGE

IMPORTANT: All new participants must complete and include a copy of your insurance card from your previous provider. Prior coverage Information: **Begin Date:** _____ **End Date:** _____

Prior Provider Name: _____

Coverage Option	Plan A - Lower Deductible	Plan B - Higher Deductible
Member Only	<input type="checkbox"/> \$ 655.75	<input type="checkbox"/> \$ 464.89
Member + Spouse	<input type="checkbox"/> \$ 1,311.49	<input type="checkbox"/> \$ 929.76
Member + Child(ren)	<input type="checkbox"/> \$ 1,245.92	<input type="checkbox"/> \$ 883.33
Member + Family	<input type="checkbox"/> \$ 1,967.23	<input type="checkbox"/> \$ 1,394.64
<input type="checkbox"/> I decline to participate in the Medical Plan		

3. DENTAL COVERAGE

Coverage Option	Dental Plan
Member Only	<input type="checkbox"/> \$41.52
Member + Spouse	<input type="checkbox"/> \$83.89
Member + Child(ren)	<input type="checkbox"/> \$109.23
Member + Family	<input type="checkbox"/> \$151.67
<input type="checkbox"/> I decline to participate in the Dental Plan	

4. VISION COVERAGE

Coverage Option	Vision
Member Only	<input type="checkbox"/> \$ 7.48
Member + One	<input type="checkbox"/> \$10.84
Member + Family	<input type="checkbox"/> \$ 19.44
<input type="checkbox"/> I decline to participate in the Vision Plan	

5. MEDICAL/DENTAL COVERAGE DEPENDENTS

If you are electing dependent medical or dental coverage, please complete the following information. Only the dependents you list will be covered. Please refer to your enrollment guide for an explanation of who qualifies as an eligible dependent. You also may be asked to provide proof of dependent eligibility. Verification from the college or university showing full time status will be required.

Dependent's Full Name	SSN	Relationship	Gender	Date of Birth	Coverage For:	Full Time Student?	Other Medical?	Other Dental?
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. COORDINATION OF BENEFITS (Complete if other health coverage exists)

Coordination of Benefits (COB) is how insurance carriers pay benefits when you are covered by more than one plan. Your plan requires that any benefit payments made must be coordinated with benefit payments made by any other group health plan that covers you.

Name of other carrier/Medicare:	<input type="checkbox"/> Medical coverage	<input type="checkbox"/> Dental coverage
Address:	City, State, Zip:	
Name of employer:	Plan/group #:	
Reason for Medicare: <input type="checkbox"/> Disabled <input type="checkbox"/> Over 65 <input type="checkbox"/> Over 65 (working) <input type="checkbox"/> ESRD		

7. SHORT TERM DISABILITY (EOI required if increasing current coverage)

<input type="checkbox"/>	STD: (60% up to a \$2,000 maximum weekly benefit)	(Enter Salary Amount) \$	\$0.28 (salary/52X60%).
<input type="checkbox"/>	Waive STD		
<input type="checkbox"/>	LTD: (60% up to a \$10,000 maximum monthly benefit)	(Enter Salary Amount) \$	\$0.76 (salary/12/\$100)
<input type="checkbox"/>	Waive LTD		

8a. GROUP TERM LIFE INSURANCE PROGRAM

Select your and your dependents supplemental life coverage levels. The deductions for this coverage are made on an after-tax basis.

Member Life Amount: \$.23/\$1,000	AD&D Amt: \$.035/\$1,000	Spouse Life \$1.54	Child Life \$1.54
<input type="checkbox"/> 1(x) salary <input type="checkbox"/> 2(x) salary <input type="checkbox"/> 3(x) salary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> \$5,000
Salary Amount: \$ (if life amount greater than \$375,000 or increasing existing coverage – Evidence of Insurability form is required)	amount equal to Member life	If electing this, please complete question on section 8b below.	# of children List names on the front of the form.

	Full Name	Relationship	%
Beneficiary:			
Beneficiary:			

8b. EVIDENCE OF INSURABILITY

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 must be completed for any employee or dependent with a “Yes” answer to the above question or if electing over \$375,000. It is also required if previously eligible and electing for the first time, or increasing coverage.

9. 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:

10. INFORMATION

I have been given the opportunity to enroll in the Wealth Advisor Benefits Plan. I authorize Wealth Advisor Benefits Plan to make 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 with 31 days of the event). I authorize payment of medical benefits to preferred providers where applicable, for those changes 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.

Member Signature _____

Date _____

Forms may be submitted via e-mail to nikki.hale@ahrensnaefconsulting.com, fax to (866) 817-3969, or mail to Wealth Advisor Benefit Plan - 5934 Hickory Hollow Court - Harrisburg, NC 28075

Please remember in addition to your monthly premium there is an initial enrollment fee of \$320/participant as well as a \$12/mo/participant administration fee. Thereafter there will be an annual fee of \$200.