# Benefits Plan Enrollment Form – Plan Year 2019

## S. Clyde Weaver, Inc. (SCW)

You must **complete and sign** this enrollment form to make your benefit elections for the **2019 Benefits Plan Year**. Submit completed form to Human Resources.

Name (Employee) _____ Gender ☐ Male ☐ Female

Address _____ DOB ____/____/____ DOH ____/____/____

_____ **Note:** If you are 65 yrs or older – please see * notation on page 3 of this form.

Home Phone _____ Social Security No. _____- _____ - _____

Mobile Phone _____ Marital Status: [ ] Single [ ] Married

**Choose reason for enrollment or update:** **Effective Date:**

☐ **New Enrollment** ☐ **Qualifying Life Event**

*Are you or any of your dependents enrolled in Medicare?* ☐ *Yes* ☐ *No*
*Reason:* ☐ *Age* ☐ *Disability* *Medicare #* _____ *Part A Date:* ___/__/___ *Part B Date:* ___/__/___

*Are you or any of your enrolled dependants covered under other medical insurance?*

*[ ] Yes [ ] No If yes, please provide Carrier name:* _____ *and Group #:* _____

*List Dependents covered under other medical insurance:*

*Name:* _____ *Date of Birth:* _____

*Name:* _____ *Date of Birth:* _____

*Name:* _____ *Date of Birth:* _____

Please complete the following for EACH of your dependents you intend to enroll in the health plan offered SCW.

| Dependent's Name | Relationship To Employee | Social Security # | Date of Birth | Gender |
|---|---|---|---|---|
| | | | | [ ] M [ ] F |
| | | | | [ ] M [ ] F |
| | | | | [ ] M [ ] F |
| | | | | [ ] M [ ] F |
| Disabled/handicapped child coverage: [ ] Documentation attached Dependent's Name: _____ | | | | [ ] M [ ] F |

**BENEFIT PLAN OPTIONS:**

**[ ] Benefit Plan Option: Medical/Rx Plan Coverage – Qualified High Deductible Health Plan**

| Medical Benefits Plan Summary 2019 | Qualified High Deductible Health Plan (HDHP) |
|---|---|
| | Loomis – Third Party Administrator |
| Deductible – In-Network (CIGNA) | $3,000 (individual)/ $6,000 (dependents) |
| Deductible – Out-of-Network | $4,000 (individual)/ $8,000 (dependents) |
| Co-Insurance – In and Out-of-Network | 100% after deductible |
| Maximum Benefit | Unlimited |
| HSA SCW Contribution | $500 (individual) / $800 (dependents) |
| *Please refer to the Summary of Benefits and Coverage for additional plan details.* | |

**The family deductibles of $6,000 In-Network / $8,000 Out-of-Network have no individual limits. In other words, the entire deductible must be met by the collection of individuals on the family plan or any one individual.** SCW's contribution AND any personal contributions may be used to offset the HSA plan deductible or any other qualified medical expenses as they are incurred.

**Please Make Your Annual Health Plan Election in the box below:**

| Elected Family Status | 2019 High Deductible Health Plan (QHDHP) |
|---|---|
| Employee Only | **[ ] $35.38/pay ($1,769.00 annual)** |
| Employee + Dependent(s) | **[ ] $82.38/pay ($4,119.00 annual)** |
| Spousal Surcharge:<br>The surcharge is applied if your spouse is eligible for health coverage with his/her employer's health plan. Spousal Certification of Coverage is required. Surcharge does not apply if your spouse is self-employed or covered under Medicare. | **[ ] $50.00/pay ($2,500.00 annual)** |
| Decline/Waive Coverage | **[ ] $0 (no cost)** |

## [ ] Declining Medical/Rx Plan Coverage:

I elect to decline Medical/Rx drug coverage offered by SCW. I am enrolled in the following:

Insurance Carrier: _____ Group # _____

Employer/Company Sponsor: _____

If you decline coverage with SCW, you are not eligible for COBRA coverage if/when you terminate employment at SCW. COBRA may be available through your other group insurance carrier.

**Benefit Plan Funding Options**

## [ ] Funding Option: Health Savings Account (HSA)

**Note: The HSA is administered by HSA Bank!**

I elect to have $_____ /week **(50 weeks only per year)** in pre-tax dollars contributed into my HSA for the 2019 Plan year. I understand this amount will be deducted from my pay on a weekly basis.

**Maximum 2019 HSA contribution:**

**Individual = $3,000 ($60 / week over 50 weeks)** **[$3,500 Fed. Max. less SCW contribution $500]**

**Dependent/Family = $6,200 ($124 / week over 50 weeks)** **[$7,000 Fed. Max. less SCW contribution $800]**

***Note: Employees age 55+ may contribute an additional $1,000 in the HSA in 2019.***

**Health Reimbursement Arrangement (HRA)**

*****Federal tax law prohibits employees enrolled in Medicare (or other federal health plans) from participating in an HSA plan. SCW is also prohibited from making contributions into the HSA. Therefore, SCW has established an HRA for the company contributions only. Employees will still be enrolled in the HDHP but company contributions from SCW will be processed through the HRA. Any employee who may be eligible for enrolling in Medicare any time during 2018 should see Human Resources for further details.

## [ ] Funding Option: Section 125 Medical/Flexible Spending Account (FSA)

Note: This option is available on the 1st of the month following six months of full-time employment at SCW.

I elect to have $_____/week (maximum = $50) or $_____ /year (maximum = $2,500) in pre-tax dollars contributed into my FSA for the 2019 Plan year. I understand this amount will be deducted from my pay on a pro-rated weekly basis.

_____ (Initials) I understand that I cannot seek reimbursement from other sources for any expense reimbursed through the HDHP/HSA accounts listed above. AND my participation in the Medical/FSA account is limited to *qualified dental and vision expenses ONLY* (dental and vision expenses may also be reimbursed from the HSA accounts).

For Section 125 Medical expenses, you will be reimbursed only for those types of medical expenses normally deductible as described in IRS Publication 502 (with some exceptions for insurance premiums) or Internal Revenue Code Section 213(d). Section 125 elected dollars cannot be changed during the plan year unless there is a qualified life event.

## [ ] Funding Option: Section 129 Dependent Care/Flexible Spending Account (FSA)

I elect to have $_____/week (maximum = $100) or $_____ /year (maximum = $5,000/joint filing or $2,500 separate filing) in pre-tax dollars contributed into my FSA for the 2019 Plan year. I understand this amount will be deducted from my pay on a pro-rated weekly basis. **If you are enrolled in the HSA plan option listed above you may also participate in Section 129 Dependent Care/FSA.**

**Please read the following list of Benefits Plan Disclaimers as they pertain to your rights and responsibilities, as well as the Benefits Plan's administrative and compliance requirements. I understand and agree to the following:**

I have enrolled for certain benefits under the **S. Clyde Weaver Health and Benefits Plan** and elect to participate in the Plan for payment of my premium contributions on a pre-tax or after-tax basis. I agree that my cash compensation will be reduced by the amounts shown above during the Plan Year or during the portion of the year that remains after the date of this Agreement. This Agreement applies only to coverage (and my salary will be reduced only for those coverages) in which I have elected to participate on a separate enrollment form/forms.
Some benefits under the Plan may/will require certain applications, health statements, or other evidence of insurability forms, and that it is solely my responsibility to complete and return all required paperwork in a timely manner. I understand that if I do not submit required paperwork that I will not be covered under those Plan benefits.

Participants may not be permitted (due to contractual obligations or Plan provisions) to change or newly elect certain Plan benefits for themselves or their dependents if the participant is not actively at work unless subject to the Family Medical Leave Act of 1993 (FMLA) or the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Choice Benefit elections are for the **January 1, 2019 to December 31, 2019 Plan Year** and cannot be changed except in the case of certain qualified status changes or qualified life event changes that are more fully described under the Plan. If a participant or any of his/her dependents experience a life event or status change, the participant is required to notify the Human Resources/Benefits Department within 31 days of the event/change (60 days for CHIPRA) if he/she wishes to exercise any rights they may have under the Plan, including HIPAA's special enrollment rules to revise or adjust their Choice Benefit elections due to such event.

Regarding the Flexible Spending Accounts – I understand that reimbursement will be available only for "qualifying medical care expenses" under federal guidelines. I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. This Plan is an annual Benefit Plan and both premiums and benefits will continue to year end.

I understand I (and my dependents) am/are ***not eligible*** to enroll in the Health Savings Account if I (and my dependents) am/are, a) covered under another health plan that ***is not*** also a qualified high deductible health plan, and b) if I (and my dependents) am/are entitled to or enrolled in Medicare Parts A or B either on account of age or disability.

I understand that if I am enrolled in the Health Savings Account that I may only participate in the Medical/Healthcare Flexible Spending Account for the purpose of submitting only eligible dental and vision expenses as all other medical/health expenses do not qualify for reimbursement due to my enrollment in the Health Savings Account.

Plan participants understand that **S. Clyde Weaver** may reduce or change this Agreement if necessary to satisfy provisions of the Internal Revenue Code.

Participants agree that all the information provided in connection with their Choice Benefit elections is correct and true and the participant understands that by knowingly providing materially false or misleading information or concealing information concerning any material fact that he/she may be committing insurance fraud, which is, subject to criminal and/or civil prosecution and penalties.

Plan participants agree to the provisions of the Plan and understand that if there are any discrepancies or inconsistencies between the contracts, Plan document and the Plan's enrollment materials or summary plan description that the contracts and the Plan document will govern.

_____

**Employee – Print Name**

_____ _____

**Employee – Signature** **Date**