___Ashley Mechanical ___ D&B Service & Insulation __Universal Metal Fabricators

DATE OF HIRE: _____ ENROLL/CHANGE EFFECTIVE DATE: _____

ENROLLMENT: ___New Hire ___Open Enrollment
___ Renew Current Dependents

Or Qualifying Event _____

CHANGE: ___Add Dependent ___Name Change
___Address Change ___Loss of Coverage
___Marriage ___Birth/Adoption
___Dependent Reached Max Age

TERMINATION: ____Employee ___ Emp & Family
____Dependent(s) Only (List Below)

Other:_____

Reason: _____

A. EMPLOYEE INFORMATION:

Employee Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

B. BENEFIT ELECTIONS

Health Plan: ___Elect or ___Decline

Plan Name: _____

_____Employee Only _____Employee/Spouse
_____Employee/Child(ren) _____Family

Dental: ___Elect or ___Decline

_____Employee Only _____Employee/Spouse
_____Employee/Child(ren) _____Family

Flexible Spending Account: ___ Elect or ___ Decline (See next page for election information)

LIST SELF AND ALL ELIGIBILE DEPENDENTS – *SS#s and DOBs are required

FULL NAME	GENDER	*DOB	*SS#	MEDICAL	DENTAL
Self				__ ADD __ TERM	__ ADD __ TERM
Spouse				__ ADD __ TERM	__ ADD __ TERM
Child				__ ADD __ TERM	__ ADD __ TERM
Child				__ ADD __ TERM	__ ADD __ TERM
Child				__ ADD __ TERM	__ ADD __ TERM
Child				__ ADD __ TERM	__ ADD __ TERM
Child				__ ADD __ TERM	__ ADD __ TERM

1. Do you, your spouse/domestic partner, or any of your dependents have any other medical or dental insurance which will be maintained in addition to this plan: ___Yes ___No

If yes, attach (or email) a copy of ID card or complete below:

Insured's name _____ Effective date: _____

Covered Individuals: ____ *Self* ___ Spouse ____ Dependents

Policy # _____Insurance carrier: _____ Employer _____

Type: ___Hospital ___Medical ___Drug ___Dental

2. Are you, your spouse, or any of your dependents enrolled in, Medicare: ___Yes ___No

If yes, attach (or email) a copy of ID card or complete below:

Insured's name _____ Part A Effective Date: _____ Part B Effective Date: _____

Insured's name _____ Part A Effective Date: _____ Part B Effective Date: _____

If you have any questions, please contact Upstate Benefit Planning:

Trisha Hollister, thollister@ubplanning.com **or 518-505-7901**
Thomas Wronowski, twronowski@ubplanning.com **or 518-813-6882**

Send Form To: **Email @** thollister@ubplanning.com **FAX @ 518-610-8194**
Mail @ Upstate Benefit Planning, PO Box 672, Kinderhook NY 12106.

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any attached riders.

I hereby consent to the release of any medical, health and/or payment information (including without limitation pharmacy and claims information) about me and my minor eligible dependents by any licensed physician, hospital, other health care provider, or authorized federal, state or local agencies to the insurance carrier or any health care providers involved in caring for me or my minor eligible dependents, as reasonably necessary to allow the insurance carrier to administer my benefits or for the insurance carrier or my health care providers to carry out treatment, payment, or health care operations functions, to the extent permitted by law. I also agree that the information released for treatment, payment and health care operations may include HIV, STD, mental health or alcohol and substance abuse information about me and my minor eligible dependents to the extent permitted by law, until I revoke this consent. I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

I have read and agree to the authorization on this form. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE_____**DATE**_____

Flexible Spending Health Care Account Election Form
Dependent Care Account Election Form

Employee Name: _____ DOB: _____ SS#: _____

OPTION 1 FLEXIBLE SPENDING ACCOUNT

___ **YES**. I elect to contribute $_____ (before taxes) for the Plan Year or $_____ per pay period to fund my account that pays qualified out-of-pocket expenses that are not covered by my employer's health plan or any other health plan.

OPTION 2 DEPENDENT CARE ACCOUNT. This pays for day care expenses for a dependent child, adult, or elder so that you may work. Eligible services include nursery school, nanny and/or before/after school care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, day camp through age 12.

___ **YES**. I elect to contribute $_____ (before taxes) for the Plan Year or $_____ per pay period to fund my account that pays qualified out-of-pocket expenses that are not covered by my employer's health plan or any other health plan.

If a second Flex Card is required, please complete dependent information:

Name: _____ ***DOB:*** _____ ***SS#*** _____

OPTION 3 PAYROLL DEDUCTION FOR PREMIUMS

___ **YES.** On the appropriate benefit enrollment form, I have enrolled in certain employer sponsored insurance benefits. I understand that my share of the premium for these benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

___ **NO.** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

IMPORTANT: If elected, my employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefits elections set forth above and that qualified expenses will be paid on a tax-savings basis. I understand that I may change my election in the event of certain changes in my status and that prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read, and understand Summary Plan Description. I understand that the take care® Card is available to pay only qualified expenses which can then not be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the Card from any other source. I understand that when using the Take Care Card, I must keep all receipts and that on occasion I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for a qualified expense, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

SIGNATURE_____**DATE**_____

Send Form To: **Email @** thollister@ubplanning.com **FAX @ 518-610-8194**
Mail @ Upstate Benefit Planning, PO Box 672, Kinderhook NY 12106.