Enrollment / Change Form 2024

- ❑ **Open Enrollment**
- ❑ **New Hire Enrollment**
- ❑ **Qualifying Life Event Change**
- ❑ **Change in Beneficiary**

Date of Change _____

❑ Marriage ❑ Birth/Adoption ❑ Other _____

❑ Divorce ❑ Change in Employment Status

❑ Death ❑ Change in Spouse's Coverage

SUPPORTING DOCUMENTATION REQUIRED

I. Employee Information (Type or print)

Name (First MI Last)	❑ Female ❑ Male	Date of Birth	Social Security #
Street Address		Date of Hire	Phone Number
City / State / Zip		Location	❑ Single ❑ Married ❑ Divorced

II. Dependent Information (List only dependents you are covering in the medical, dental or vision plans)

Refer to your Benefits Program Guide for dependent eligibility definitions. Proof of eligibility is required.

Name (First MI Last)	Relationship	Gender (circle)	Date of Birth	Social Security #	Medical (circle)	Dental (circle)	Vision (circle)
		F M			Y N	Y N	Y N
		F M			Y N	Y N	Y N
		F M			Y N	Y N	Y N
		F M			Y N	Y N	Y N
		F M			Y N	Y N	Y N
		F M			Y N	Y N	Y N

Do any dependents have coverage under another plan? ❑ Yes ❑ No

If yes, provide the name(s) of covered individual(s), carrier and policy number:

III. Benefit Elections

Medical (includes prescription drugs) - Weekly Per Pay Period Cost (Please check one)

BCBSTX Medical - High Deductible Health Plan (HDHP)

- ❑ $5.49 Employee Only
- ❑ $102.12 Employee + Spouse
- ❑ $105.17 Employee + Child(ren)
- ❑ $201.81 Employee + Family
- ❑ Waive Coverage ❑ Drop Coverage

H.S.A. Bank Contribution

I wish to contribute the following amount per pay period into my Health Savings Account.

$ _____

* Superior will match your contribution 2 to 1, up to $2,000

Dental and Vision - Weekly Per Pay Period Cost (Please check one)

BCBSTX Dental Plan

- ❑ $8.00 Employee Only
- ❑ $15.99 Employee + Spouse
- ❑ $21.40 Employee + Child(ren)
- ❑ $31.18 Employee + Family
- ❑ Waive Coverage ❑ Drop Coverage

BCBSTX Vision Plan

- ❑ $2.19 Employee Only
- ❑ $4.15 Employee + Spouse
- ❑ $4.37 Employee + Child(ren)
- ❑ $6.42 Employee + Family
- ❑ Waive Coverage ❑ Drop Coverage

Voluntary Life and Accidental Death & Dismemberment (AD&D)			
One America Life Insurance **Please refer to attached rate sheet for costs based on your age. In certain cases, coverage will be subject to proof of good health or evidence of insurability (EOI). Your coverage will not be in effect until the EOI is complete and approved. Contact Human Resources for the EOI form. If you would like to enroll your spouse or child(ren) in coverage, you must also elect coverage for yourself.**			
❑ **Employee** You may elect coverage for yourself in increments of $10,000 up to $500,000, but cannot exceed 5 times your annual salary. Miminum benefit amount is $10,000.	❑ **Elect Coverage** Amount Elected $	❑ **Waive Coverage**	**Weekly Cost** $
❑ **Spouse** You may elect coverage for your Spouse in increments of $5,000 up to 50% of your Optional insurance amount. Minimum benefit amount is $5,000, up to a maximum of $250,000	❑ **Elect Coverage** Amount Elected $	❑ **Waive Coverage**	**Weekly Cost** $
❑ **Child** Birth to 6 months is $1,000. 6 months through age 25 is $10,000.	❑ **Elect Coverage** Amount Elected $	❑ **Waive Coverage**	**Weekly Cost** $

IV. Beneficiary Information for Life Insurance. PLEASE COMPLETE FOR BASIC LIFE & VOLUNTARY LIFE (IF APPLICABLE).

Name (First MI Last)	Relationship	Date of Birth	Address	Benefit Percentage
Primary (Total must equal 100%)				
Name (First MI Last)	**Relationship**	**Date of Birth**	**Address**	**Benefit Percentage**
Contingent (Total must equal 100%)				

I have read and understand the information contained in this benefits enrollment/change form. I authorize my employer to take payroll deductions, as required, for coverage as selected. I understand I cannot change or revoke any of these elections during the plan year unless I I experience a Qualifying Life Event, as defined by the Internal Revenue Service (IRS). I certify the above information is true and can show proof, if requested. I understand that submission or filing of an application or claim constitutes fraud if it contains false or deceptive statements with intent to defraud or to facilitate a fraud against an insurer.

Employee Signature: _____

Date: _____