EARNHARDT AUTO CENTERS – 2017-2018 BENEFIT ENROLLMENT FORM

Employee: _____ **Dealership:** _____ **SSN:** _____ **Gender** _____

Birth Date: _____ **Date of Hire:** _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

MEDICAL – BLUE CROSS BLUE SHIELD OF AZ (PER PAY PERIOD)

☐ New Hire ☐ Changes

	Red Plan	*With HRA*	White Plan	*With HRA*	Blue Plan	*With HRA*
Employee Only	☐$112.50	☐$102.50	☐$ 76.50	☐$ 66.50	☐$ 53.50	☐$ 43.50
Employee + Spouse	☐$460.00	☐$450.00	☐$378.50	☐$368.50	☐$324.00	☐$314.00
Employee + Child(ren)	☐$375.00	☐$365.00	☐$297.50	☐$287.50	☐$249.00	☐$239.00
Employee + Family	☐$672.50	☐$662.50	☐$505.00	☐$495.00	☐$435.00	☐$425.00

☐ I decline medical coverage for myself and my dependents. If waiving, please enter reason code (see back for list of codes) _____

Will you or your dependents be covered by other health insurance in addition to BCBSAZ? ☐ Yes ☐ No

DENTAL – ASSURANT (PER PAY PERIOD)

☐ New Hire ☐ Changes

	PrePaid – DHMO (AZ ONLY)	PPO Dental Plan
Employee Only	☐$ 6.93	☐$20.34
Employee + Spouse	☐$11.27	☐$39.78
Employee + Child(ren)	☐$15.29	☐$46.30
Employee + Family	☐$17.94	☐$69.88

*Prepaid Facility ID# _____

*__Please Note:__ If you select the PrePaid DHMO Plan, you ***MUST*** designate a dentist in the Heritage Series network. If a facility ID# for the dentist of your choice is not provided, the closest in-network dentist to your home will be automatically selected. A list of dentists can be found at www.assurantemployeebenefits.com.

☐ I decline dental coverage for myself and my dependents.

VISION - EYEMED (PER PAY PERIOD)

☐ New Hire ☐ Changes

	Vision Plan
Employee Only	☐$2.84
Employee + Spouse	☐$5.38
Employee + Children	☐$5.66
Employee + Family	☐$8.32

☐ I decline vision coverage for myself and my dependents

SHORT & LONG TERM DISABILITY – MUTUAL OF OMAHA

☐ New Hire ☐ Changes

Coverage Selection:

Select the insurance plans that meet your needs. Have your Plan Highlights sheets and Premium Table sheets handy for reference. Plans may have limitations, exclusions, reduction in benefit provisions and terms under which coverage may be continued in force or terminated. **Read your certificate of insurance carefully.**

Short Term Disability: Employee: ☐ Yes ☐ No* Benefit = 60% weekly earnings up to a maximum $1,300 per week

Long Term Disability: Employee: ☐ Yes ☐ No* Benefit = 60% covered monthly salary up to a maximum $7,500 per month

(Late applicant: Evidence of Insurability (EOI) is required – see your Benefits Administrator for a form.)

*** If you are newly eligible and you check "no," please note that if you desire insurance on yourself at a later date: (1) you may be required to furnish, at your own expense, evidence of each person's insurability; and (2) Mutual of Omaha will have the right to refuse your request.**

_____ Date of Hire

_____ Job Title or Position

_____ # hours worked per week

Are you actively performing all the duties of your occupation or profession? ☐ Yes ☐ No

If not, please explain:

SHORT & LONG TERM DISABILITY – MUTUAL OF OMAHA – CONTINUED ☐ New Hire ☐ Changes

Beneficiary Information for Long Term Disability:

Your Beneficiary's Name** First Middle Initial Last	Relationship to You	Date of Birth Month/Day/Year	Social Security Number
Primary			
Contingent			

** Important: When naming a married beneficiary, show the name as Jane J. Doe, not Mrs. John H. Doe.
A contingent beneficiary will receive benefits only if the primary beneficiary does not survive you. You are automatically the beneficiary for dependent insurance, unless you otherwise specify. To designate more than one primary or contingent beneficiary, please use a separate sheet of paper and attach it to this form. Your intentions must be clearly set forth.

Additional Information:
If you selected STD and/or LTD Insurance, complete the following:

Annual Base Salary: $_____ I receive my Paycheck: ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly
☐ Other_____

Read, Sign and Date Below:
I understand and agree that: The information provided on this Enrollment Application is true and correct to the best of my knowledge. The insurance requested on this Enrollment Application will become effective in accordance with the individual effective date in the certificate of insurance; any amount subject to evidence of insurability will not become effective until approved by Mutual of Omaha. Coverage is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and for enrolled dependents confined to a hospital or at home. Benefits are subject to terms and conditions of the policy. For a plan with age-banded rates, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next. If payroll deduction of premiums begins prior to Mutual of Omaha's processing of this Enrollment Application, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned. (Please sign the form below.)

Employee's signature_____ Date _____

LIFE AND AD&D – MUTUAL OF OMAHA ☐ Yes, I would like to enroll or change my coverage

Job title or position	Employee hire date	Number of hours per week	Earnings $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other _____	Married ☐ Yes ☐ No	Children ☐ Yes ☐ No

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.
DEPENDENT INFORMATION–Required if Dependent coverage applies

Dependent Name (Last Name, First Name)	Date of Birth	Gender	SSN	Relationship

NOTE – Coverage not elected will be assumed refused even if not specifically refused
Employee Choice Life Benefits – You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Accept	Refuse	Coverage
☐	☐	Employee Life and Accidental Death & Dismemberment – Amount _____
☐	☐	Spouse Life – Amount _____
☐	☐	Child Voluntary Life – Amount _____

LIFE & AD&D – MUTUAL OF OMAHA	☐ Yes, I would like to enroll or change my coverage				
BENEFICIARIES					
Last name First MI	**Relationship***	**SSN**	**Date of Birth**	☐ Primary ☐ Secondary	
				☐ Primary ☐ Secondary	

*If beneficiary is not related to you, please provide date of birth, Social Security Number, and full address.
1) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 5) If your designation does not fit the above arrangement, please contact Mutual of Omaha for the appropriate forms.

ELIGIBLE DEPENDENTS (MEDICAL, DENTAL, VISION)

Indicate any changes in dependents or add new dependents. Check the boxes of the plans (medical, dental or vision) for each dependent to indicate the coverage for that dependent. All information must be completed for each dependent.

Name	SSN	Gender	Date of Birth	Relationship	Medical	Dental	Vision	Remove
_____	_____	____	_____	_____	☐	☐	☐	☐
_____	_____	____	_____	_____	☐	☐	☐	☐
_____	_____	____	_____	_____	☐	☐	☐	☐
_____	_____	____	_____	_____	☐	☐	☐	☐

I am applying for the coverage indicated on this form.

CAN ELECTIONS BE CHANGED DURING THE PLAN YEAR?

You cannot change your annual elections unless a qualified status change occurs.

The IRS defines these changes. They are change in marital status (marriage, divorce or legal separation); birth or adoption of an eligible child; death of a dependent; dependent child reaches the maximum age limit for coverage; loss or gain of spouse's group health coverage; change in employment status/class for you or your spouse; employee, spouse, and/or dependent entitlement to Medicare/AHCCCS; COBRA qualifying event; court order; or significant change in cost or coverage options. If the change is not one listed above, it is not a status change by the IRS. The requested change must be consistent with the event.

WHEN CAN I JOIN?

You can join once per year during open enrollment.

Each year your participation will continue unless you notify us differently. If you waive participation at this time, you must wait until the next open enrollment unless there is a qualified status change. New hires can join mid-year once they are eligible for health coverage. If you have other questions throughout the year, refer to your Summary Plan Description.

☐ **I UNDERSTAND AND AUTHORIZE** Earnhardt Management Company to make the necessary deductions/reductions from my paycheck to cover the premium for the coverage(s) which I have elected under the Earnhardt Management Company Employee Benefits Program. I further understand the deductions/reductions will be taken on a pre-tax basis if I elect medical, dental or vision coverage(s) which require a personal contribution under the Section 125 Premium Only Plan (POP). ***I understand that I cannot change any of my elections unless I have a qualifying change in family status, per Section 125 of the Internal Revenue Service Code.***

I certify that all information on this form is true and correct to the best of my knowledge and I agree to the contribution rates noted above.

Employee Signature: _____ Date: _____

ACKNOWLEDGMENTS, AGREEMENTS AND AUTHORIZATIONS APPLICABLE TO EMPLOYMENT-BASED HEALTH PLAN COVERAGE OFFERED BY OR ADMINISTERED THROUGH BLUE CROSS BLUE SHIELD OF ARIZONA (BCBSAZ), an independent licensee of the Blue Cross Blue Shield Association

On behalf of myself and the persons listed on this application as eligible dependents, I acknowledge, agree, and authorize the following:

A. I have received information summarizing the terms and conditions of the health coverage available through my employment ("Coverage"). The Coverage is either (a) group health insurance that my employer has purchased from BCBSAZ; or (b) a group benefit plan, for which BCBSAZ provides certain administrative, claims payment, and utilization management services, and provider network access, but does not assume financial risk or obligation of claims.

B. I have carefully reviewed this entire application form and the answers I've provided. My answers are material to BCBSAZ. BCBSAZ will rely on my information to determine my employer group's eligibility for BCBSAZ coverage or administrative services, and to establish premium rates or administrative fees for my employer group.

C. My application includes any other enrollment forms I complete when applying for this coverage. This completed application becomes a part of my group's contract with BCBSAZ, except for any provisions related to life and disability coverage or separate financial accounts (HSA, FSA, HRA).

D. BCBSAZ does not underwrite or guarantee any separate life and/or disability insurance that may be offered by my employer group health plan. BCBSAZ is independent from any companies that offer such coverage.

E. BCBSAZ does not administer or guarantee any separate financial account or arrangement (HSA, HRA, FSA) that may be part of the group benefit plan sponsored by my employer. BCBSAZ is independent from any companies that administer such coverage or accounts.

F. My coverage shall become effective only when BCBSAZ: (1) reviews and accepts this application and (2) issues coverage to my employer group and me on effective dates assigned by BCBSAZ in accordance with the employer's terms for coverage.

G. The contract between my employer group and BCBSAZ controls the administration of this group coverage. The Coverage is subject to change, as permitted under applicable state and federal law, and in accordance with the terms of the contract between my employer and BCBSAZ. My employer is responsible for notifying me of all changes, including termination of the employer group contract for any reason.

H. If the contract between my employer group and BCBSAZ is terminated, I may be eligible for other coverage as required under state and/or federal law.

I. BCBSAZ, its reinsurers, or their respective authorized representatives may need to obtain medical information to process claims, and may collect personal information from someone other than me or one of the proposed covered persons. I authorize any physician, practitioner, hospital, clinic or other health related provider or facility to furnish my health information, including information related to drug use, alcoholism, mental illness, HIV, and AIDS (but not genetic testing or family history), to BCBSAZ, its reinsurers, and their respective authorized representatives. BCBSAZ may use this information, and any of my information already in its possession to process claims. When permitted by law BCBSAZ may disclose this information to third parties without my permission.

J. If I am declining enrollment for myself or my dependents (including my spouse) because of other health or dental coverage, I may be able to enroll myself and my dependents in this BCBSAZ plan if my dependents or I lose eligibility for the other coverage (or if the employer group stops contributing towards my or my dependents' other coverage). I must request enrollment in this Coverage within 30 days after other coverage ends. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet.

K. If I have a new dependent as a result of marriage, birth, adoption or placement of adoption, I may be able to enroll myself and/or my dependents, if I request enrollment within 31 days (60 days for small groups*) after marriage, birth adoption or placement of adoption. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet. (To request special enrollment or obtain more information contact: Group Enrollment Services at (602) 864-4456 or (800) 232-2345, ext. 4456.)

L. Information regarding other health plan coverage is not used to determine pre-existing conditions for BCBSAZ plans beginning or renewing on or after January 1, 2014.

M. I am responsible for any costs associated with obtaining medical records needed to process claims.

N. By including my e-mail address on this form, I authorize BCBSAZ to send me information via e-mail. I can change my e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.

O. Federal statute and BCBSAZ business processes require BCBSAZ or my employer plan sponsor to obtain the Social Security number (SSN) for most applicants.

Reason Codes for Declining/Waiver Coverage
(subject to BCBSAZ's Group Underwriting Participation Guidelines)

A – Does not wish to be covered – no other coverage
B – Covered by spouse's or parents' employer group plan
C – Covered by TRICARE
D – Covered by AHCCCS
E – Covered by HIS (Indian Health Services)
F – Covered by Medicare
G – Married Co-Workers
H – Individual coverage purchased directly from carrier
I – Individual coverage purchased on Healthcare Marketplace

*Employers are considered small groups for purposes of the Affordable Care Act (ACA) if the average number of total employees on business days during the previous calendar year is 50 or fewer.