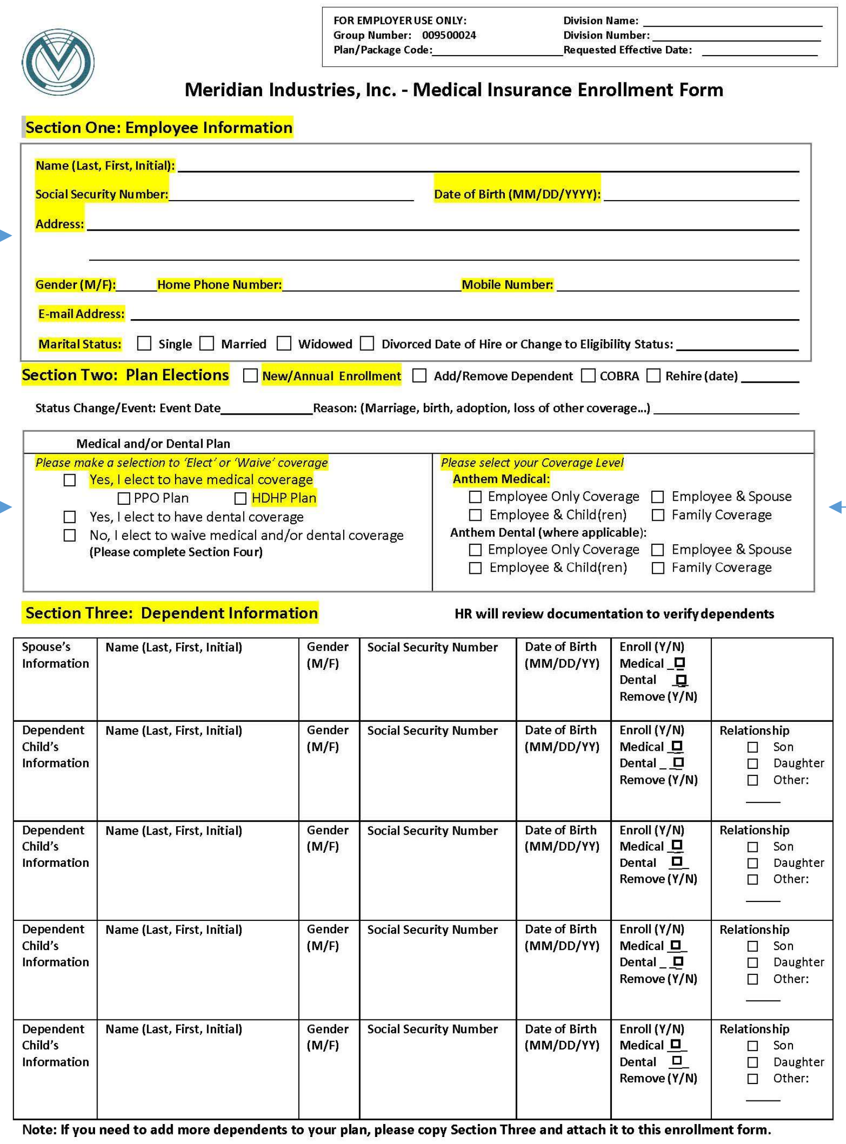
HOW TO ENROLL IN HDHP?

*Complete section one if you are enrolling

*Mark that you want to enroll in the PPO medical plan



FOR EMPLOYER USE ONLY:
Group Number: 009500024
Plan/Package Code:____________________
Division Name: ____________________
Division Number: ____________________
Requested Effective Date: ____________________

Meridian Industries, Inc. - Medical Insurance Enrollment Form

Section One: Employee Information

Name (Last, First, Initial): ______________________________
Social Security Number:____________________ Date of Birth (MM/DD/YYYY): ____________________
Address: ______________________________
____
Gender (M/F):______ Home Phone Number:____________________ Mobile Number: ____________________
E-mail Address: ______________________________
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date of Hire or Change to Eligibility Status: ______________

Section Two: Plan Elections

☐ New/Annual Enrollment ☐ Add/Remove Dependent ☐ COBRA ☐ Rehire (date) ________

Status Change/Event: Event Date____________Reason: (Marriage, birth, adoption, loss of other coverage…) ______________

Medical and/or Dental Plan

Please make a selection to 'Elect' or 'Waive' coverage
- ☐ Yes, I elect to have medical coverage
  - ☐ PPO Plan ☐ HDHP Plan
- ☐ Yes, I elect to have dental coverage
- ☐ No, I elect to waive medical and/or dental coverage **(Please complete Section Four)**

Please select your Coverage Level

Anthem Medical:
- ☐ Employee Only Coverage
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Family Coverage

Anthem Dental (where applicable):
- ☐ Employee Only Coverage
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Family Coverage

Section Three: Dependent Information

HR will review documentation to verify dependents

Spouse's Information	Name (Last, First, Initial)	Gender (M/F)	Social Security Number	Date of Birth (MM/DD/YY)	Enroll (Y/N) Medical _☐ Dental _☐ Remove (Y/N)	
Dependent Child's Information	Name (Last, First, Initial)	Gender (M/F)	Social Security Number	Date of Birth (MM/DD/YY)	Enroll (Y/N) Medical ☐ Dental _☐ Remove (Y/N)	Relationship ☐ Son ☐ Daughter ☐ Other: _____
Dependent Child's Information	Name (Last, First, Initial)	Gender (M/F)	Social Security Number	Date of Birth (MM/DD/YY)	Enroll (Y/N) Medical ☐ Dental ☐ Remove (Y/N)	Relationship ☐ Son ☐ Daughter ☐ Other: _____
Dependent Child's Information	Name (Last, First, Initial)	Gender (M/F)	Social Security Number	Date of Birth (MM/DD/YY)	Enroll (Y/N) Medical ☐ Dental _☐ Remove (Y/N)	Relationship ☐ Son ☐ Daughter ☐ Other: _____
Dependent Child's Information	Name (Last, First, Initial)	Gender (M/F)	Social Security Number	Date of Birth (MM/DD/YY)	Enroll (Y/N) Medical ☐ Dental ☐ Remove (Y/N)	Relationship ☐ Son ☐ Daughter ☐ Other: _____

Note: If you need to add more dependents to your plan, please copy Section Three and attach it to this enrollment form.

*Mark which plan type you would like

*If you are adding dependents, insert their information in section three

HDHP: Page 2

*Complete the authorization section by signing & dating

*Sign & date section five.

Section Four: Waiver of Group Health Benefits & Notice of Special Enrollment Rights

If you are electing to waive coverage, please complete the following: ***I am waiving coverage due to :***

- ☐ My preference not to have coverage
- ☐ Coverage under my spouse's plan – name of carrier: _____
- ☐ Other coverage – name of carrier: _____

This other coverage is:

☐ Individual ☐ COBRA ☐ Medicare ☐ Medicaid ☐ TRICARE (formerly CHAMPUS) ☐ Employer-Sponsored Group
☐ Plan State or Federal Marketplace Exchange

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I understand that if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 31 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Authorization

I certify that the facts above are true, correct and complete without misrepresentation of any kind. I understand that if any of the information on this document is discovered to be incorrect, false or misleading or if there are any misrepresentations or omissions of any kind, I may be subject to disciplinary action, up to and including termination.

Employee Signature:_____Date_____

Section Five: Section 125 Premium Only Plan (POP) Salary Reduction Information

Unless you request otherwise in writing, your portion of medical, dental and vision premiums for the benefits you elect will be withheld on a pre-tax basis. If your portion of premiums is withheld on a pre-tax basis, you will not be allowed to change your election during the plan year unless you have a change in status or other qualifying event as defined in the Plan and IRS regulations. Your eligible premiums are subtracted from your gross pay before federal, state, and Social Security (FICA) taxes are applied. By reducing your gross taxable income, you lower the amount of your income that can be taxed.

- Your annual tax withholding (W-2) statements will reflect your reduced taxable income.
- Your *gross annual earnings* are not impacted by participating in the POP. This amount will continue to be used to determine any future salary increases and/or 401(k) contributions (if applicable).
- Social Security taxes are reduced on salary amounts up to the IRS maximum allowance. If you earn more than that, your tax savings might be slightly less because you may not get the full advantage of paying less FICA taxes. However, you will still get the advantage of paying less Federal and State income taxes. Your Social Security benefit may also be slightly reduced as a result of your election.
- The administrator is authorized to automatically adjust the amount of your salary reduction if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for the benefits you elected.
- Prior to the first day of each Plan Year if you do not return a new enrollment form you will be treated as having elected to continue this benefit election for the new Plan Year. This salary reduction agreement will continue by its terms in the amount of the required contribution for the benefit option for the new Plan Year.

Employee Signature:_____**Date:** _____

Please return this form to Human Resources when completed within 31 days of hire or during the annual enrollment period to make changes to your elections and/or renew your waiver of coverage.