METRO TRANSPORT GROUP

2023 Company's Enrollment/Change Form

Employee Information – Please complete all employee information.		
Employee Name (Last, First, MI):		
Hire Date:	Date of Birth:	
Home Address:		
SS#	Sex:	
City:	State:	Zip:

Coverage Elections

Medical Coverage — Provided by UHCRV

Please check the box to ELECT or WAIVE your medical plan option. If you are enrolling an eligible dependent, complete the information in DEPENDENT INFORMATION. ******Pediatric Dental & Vision is Not Included******

Weekly Rates:	**Option 1 / HDHP Plan Base Plan**	**Option 2 / PPO Buy-Up Plan**
Employee	☐ $53.08	☐ $76.64
Employee + Spouse	☐ $157.55	☐ $204.67
Employee + Child(ren)	☐ $141.88	☐ $185.47
Family	☐ $246.36	☐ $313.50

◯ I do not wish to participate in Medical Coverage.

Limited Medical Plan Coverage — Provided by Companion Life

Please check the box to ELECT or WAIVE your Limited Medical plan option. If you are enrolling an eligible dependent, complete the information in DEPENDENT INFORMATION.

Weekly Rates:

Employee	☐ $11.54
Employee + Spouse	☐ $37.19
Employee + Child(ren)	☐ $32.83
Family	☐ $72.59

◯ I do not wish to participate in Limited Medical Plan Coverage.

Voluntary Dental Coverage — Provided by Mutual of Omaha

Please check the box to ELECT or WAIVE your dental plan option. If you are enrolling an eligible dependent, complete the information in DEPENDENT INFORMATION.

Weekly Rates:

Employee	☐ $6.25
Employee + Spouse	☐ $12.49
Employee + Child(ren)	☐ $13.91
Family	☐ $21.18

◯ I do not wish to participate in Dental Coverage.

Voluntary Vision Coverage — Provided by Mutual of Omaha

Please check the box to ELECT or WAIVE your vision plan option. If you are enrolling an eligible dependent, complete the information in DEPENDENT INFORMATION.

Weekly Rates:

Employee	☐ $1.31
Employee + Spouse	☐ $2.48
Employee + Child(ren)	☐ $2.91
Family	☐ $4.09

◯ I do not wish to participate in Vision Coverage.

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Dependent Information – All information must be complete in order to enroll dependents.							
Please list all of the eligible dependents you are enrolling in any company-sponsored benefits.							
Name	**SSN**	**Relationship**	**Gender M/F**	**Date of Birth (mm/dd/yyyy)**	**Med**	**Den**	**Vis**
		Spouse			☐	☐	☐
		Child			☐	☐	☐
		Child			☐	☐	☐
		Child			☐	☐	☐
		Child			☐	☐	☐

Basic Life and AD&D Life Insurance	Provided by Mutual of Omaha
Basic Life	☒ **Automatically enrolled in $25,000 employee coverage upon eligibility**

Beneficiary Designation – For Employer-Paid Life Insurance					
Name	**SSN**	**Relationship**	**Date of Birth (mm/dd/yyyy)**	**Primary (P) /Contingent (C) (circle P or C)**	**Benefit Percentage (Must equal 100%)**
				P C	%
				P C	%
				P C	%
				P C	%

Authorization - *Enrollment must occur within 30 days from the date the employee becomes eligible or experiences a qualified status change.*

I hereby apply for insurance and/or self-funded benefits and understand that if I am not active at work for the required number of hours according to the PLAN document at the time my application is approved, the coverage is not effective until the date requirement is met. I authorize any necessary pre-tax deductions from my salary for any contribution required.

In compliance with HIPPA Privacy Rules a Covered Entity (Metro Transport) may not use or disclose Protected Health Information (PHI), except, for treatment, payment and plan operations. Health information is defined as any information that is created or received by a Covered Entity or an employer and relates to the past, present or future physical or mental health of an individual. A special provision of the Privacy Rule permits a health plan, health insurance carrier to disclose PHI to the employer, as plan sponsor, if certain conditions are met.

I authorize the changes made above and the necessary deductions from my payroll check.

Employee Signature _____ Date _____