TeamCraft Roofing

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM, FRONT AND BACK

EMPLOYEE NAME (LAST, FIRST, MI)	SOCIAL SECURITY NO.	
SEX ❑ MALE ❑ FEMALE	DATE OF BIRTH (MM/DD/YYYY)	# OF ELIGIBLE CHILDREN
EMPLOYEE STREET ADDRESS	CITY	STATE
	ZIP CODE	COUNTY
HOME TELEPHONE	WORK TELEPHONE	EMAIL ADDRESS
MARITAL STATUS	DATE OF MARRIAGE	SPOUSAL DATE OF BIRTH
SPOUSE EMPLOYED FULL TIME? ❑ YES ❑ NO		

PLAN OPTION ELECTION

MEDICAL PLAN OPTION ❑ **PPO** ❑ **NONE** ❑ **BASIC**	MEDICAL LEVEL OF COVERAGE ❑ EMPLOYEE ONLY ❑ EMPLOYEE + ONE* ❑ FAMILY* *COMPLETE DEPENDENT SECTION
DENTAL PLAN OPTION ❑ **YES** ❑ **NONE**	DENTAL LEVEL OF COVERAGE ❑ EMPLOYEE ONLY ❑ EMPLOYEE + ONE* ❑ FAMILY* *COMPLETE DEPENDENT SECTION

TOBACCO STATUS:

Please provide the information requested as it pertains to your use of tobacco.

Do you currently use smoke/ use tobacco? ❑ Yes ❑ No

BENEFITS ADMINISTRATION SECTION

EFFECTIVE DATE	PPO
OCCUPATION	DIVISION
FULL-TIME EMPLOY DATE	PART TIME EMPOY DATE
	❑ HOURLY ❑ SALARIED

❑ NEW ENROLLEMENT

CONTINUOUS COVERAGE EFFECTIVE DATE

❑ SPECIAL ENROLLMENT SITUATION
❑ LATE / OPEN ENROLLMENT

❑ FULL-TIME ❑ ACTIVE
❑ PART-TIME ❑ COBRA
❑ RETIREDo

❑ TERMINATION
❑ VOLUNTARY ❑ EMPLOYEE
❑ INVOLUNTARY ❑ DEPENDENT

❑ ENROLLMENT CHANGE
❑ NAME ❑ STATUS CHANGE
❑ ADDRESS ❑ RE-ENROLLMENT
❑ BENFICIARY ❑ OPEN ENROLLMENT
❑ OTHER ______________________

I testify that the above information is true and correct to the best of my knowledge.

DATE

BENEFIT ADMINISTRATOR SIGNATURE

DEPENDENT INFORMATION FOR THOSE ELECTING BENEFITS AND RESIDING IN U.S.

RELATIONSHIP TO APPLICANT	PERSONAL INFORMATION			DISABLED DEPENDENT?	COVERED UNDER ANOTHER PLAN?	OTHER PLAN INFORMATION
SPOUSE	NAME (LAST, FIRST, MI)		SEX		❑ YES ❑ NO	NAME OF INSURANCE CARRIER
	DATE OF BIRTH	SOCIAL SECURITY NO				EFFECTIVE DATE OF COVERAGE
CHILD	NAME (LAST, FIRST, MI)		SEX	❑ YES ❑ NO	❑ YES ❑ NO	NAME OF INSURANCE CARRIER
	DATE OF BIRTH	SOCIAL SECURITY NO				EFFECTIVE DATE OF COVERAGE
CHILD	NAME (LAST, FIRST, MI)		SEX	❑ YES ❑ NO	❑ YES ❑ NO	NAME OF INSURANCE CARRIER
	DATE OF BIRTH	SOCIAL SECURITY NO				EFFECTIVE DATE OF COVERAGE
CHILD	NAME (LAST, FIRST, MI)		SEX	❑ YES ❑ NO	❑ YES ❑ NO	NAME OF INSURANCE CARRIER
	DATE OF BIRTH	SOCIAL SECURITY NO				EFFECTIVE DATE OF COVERAGE

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PLAN DECLARATION

I understand that elections will remain in effect until the last day of the Plan Year for which they are effective. I understand further that if there is a significant change in the cost of coverage under the Plan, the Employer m ay increase automatically, during the Plan Year, the payroll deductions I am required to make per pay period to purchase the benefits I have elected. I understand further that the payroll deduction elections set forth will continue in effect notwithstanding any reductions in the benefits I have elected. In addition, I understand that I may change elections during the Plan Year only i f (i) I experience a "status change", as defined under applicable law, and if my change in elections is consistent with that "status change", (ii) I exercise Special Enrollment Period Rights (as described in the Notice of Special Enrollment Period Rights below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage or for certain other reasons. I understand further that, if I do not complete and file a new Election Form during the next annual election period, my elections will continue in effect until changed on a subsequent Election Form during a subsequent annual election period or until changed incident to a "status change" or a significant change in the coverage or a significant increase in the cost of coverage under the Plan, and I hereby agree to any increases in my salary reduction in any subsequent periods to pay for any increases in the cost of coverage in those period(s). I understand that the elections noted may need to be modified by the Employer to insure that the Plan complies with applicable tax rules.

ELECTION INFORMATION

Unless I waive coverage, I understand that my employer will adjust my salary to pay for premiums or contributions under the Medical/Vision benefits and/or Dental Benefits I have elected for myself and/or my listed dependents on this form on a pre-tax basis.

I understand that my waiver I have elected for myself and eligible dependents will remain in force throughout the plan year, unless I have incurred one of the events explained in the Notice of Special Enrollment Periods or Summary Plan Description, which I have been provided.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you decline enrollment in the Plan's health coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan's health coverage, provided that you request enrollment within 30 days (unless other coverage is Medicaid, request enrollment within 60 days) after your dependent's other coverage ends for one of the following reasons:

(1) you lose eligibility (or your dependent loses eligibility) for that other coverage;

(2) employer contributions for that other coverage cease; or

(3) if that other coverage is COBRA continuation coverage, the COBRA coverage is exhausted.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan's health coverage, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you are declining to enroll yourself or an eligible dependent for health coverage because you have (or your dependent has) existing health coverage, your employer may require that you provide evidence of that existing coverage, as a condition for preserving any future special enrollment rights that you or your dependent may have if the existing coverage ceases. If the employer requires such information, you will receive a separate form to complete.

SIGNATURE

EMPLOYEE SIGNATURE	DATE