Benefit Election Form

April 1, 2019 - March 31, 2020

ROADVANTAGE® F&I Programs

All employees must complete section A and B regardless of waiving or enrolling in benefits

A. Enrollment Type - *Check One* : ☐ Open Enrollment ☐ Status Change ☐ New Hire ☐ Other

Date of Hire: _____/_____/_____

Coverage Effective Date: _____/_____/_____

Qualifying Event Type: _____

Date of Event: _____/_____/_____

B. Personal Information

LAST NAME	FIRST NAME	Middle Initial

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER (*Circle One*)	
		M / F	

MAILING ADDRESS: (Check box if new address ☐) **CITY** **STATE** **ZIPCODE**

TELEPHONE	EMAIL	

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

C. Employment Information

Job Occupation:	Salary Amount:	Salary Mode:
		☐ Yearly ☐ Monthly (12) ☐ Bi-Weekly (26) ☐ Semi-Monthly (24) ☐ Weekly (52) ☐ Hourly

2019-2020 BENEFIT ELECTIONS

D. Health Plan ☐ Elect/Change - Complete Section Below ☐ Waive

To Elect/Change coverage please select: Medical Plan and Coverage Level.

To waive health coverage please check the waive box above.

* *If you are covering Dependents, please complete* ***Section G.***

Summary of Employee Monthly Costs

Medical Plan Options				
Plan Options	Employee Only	Employee + Spouse*	Employee + Child(ren)*	Employee + Family*
BCBS MTBCP713	☐ $0.00	☐ $716.60	☐ $475.26	☐ $1,161.51

E. Dental Plan ☐ Elect/Change - Complete Section Below ☐ No Change ☐ Waive

To Elect/Change coverage please select: Dental Plan and Coverage Level.

To waive dental coverage please check the waive box above.

* *If you are covering Dependents, please complete* **Section G.**

Summary of Employee Monthly Costs

Dental Select Dental Coverage				
Plan Options	Employee Only	Employee + Spouse*	Employee + Child(ren)*	Employee + Family*
Guardian NAP / Value Vision Plan	☐ $0.00	☐ $42.09	☐ $58.04	☐ $100.13

Please circle NAP or Value

F. Vision Plan ☐ Elect/Change - Complete Section Below ☐ No Change ☐ Waive

To Elect/Change coverage please select: Vision Plan and Coverage Level.

To waive Vision coverage please check the waive box above.

* *If you are covering Dependents, please complete* **Section G.**

Summary of Employee Monthly Costs

Dental Select Vision Coverage				
Plan Options	Employee Only	Employee + Spouse*	Employee + Child(ren)*	Employee + Family*
Guardian Vision Plan	☐ $8.71	☐ $14.66	☐ $14.96	☐ $23.67

G. DEPENDENT INFORMATION

List all eligible dependents to be enrolled in the plans selected above

Last Name	First Name	Date of Birth *mm/dd/yyyy*	GENDER	Social Security Number	Relationship
		/ /	M / F		Spouse
		/ /	M / F		Child
		/ /	M / F		Child
		/ /	M / F		Child
		/ /	M / F		Child

- **Do all plan enrollees live at the same address as the employee?** Yes ☐ No

If no, list name & address:

_____

H. Insurance Deduction Agreement

I have read and understand the explanation I have received regarding my options under **Vantage Administration**. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. **I acknowledge that my election is irrevocable unless there is a change in my status**. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility; a change in residence for you, your spouse or children; or your dependents either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances; or a change in my or my spouse's employment status. I hereby apply for the options listed above. If necessary, I authorize **Vantage Administration** to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force until **03/31/2020** unless my family status changes.

Employee Name _____
(Please Print)

Employee Signature _____ **Date** _____

Questions? Contact your Gus Bates Account Manger, Sylvia Uranga, at sylvia@gusbates.com or call (817) 529-5314