Place Services
2016 / 2017 Election Form

First Name: _____ Last Name: _____ SSN: _____

Gender _____ Date of Birth _____ Phone _____ Hire Date _____

Address _____ City _____ Zip _____

Email _____

Please check the box next to each line of coverage you wish to elect or decline. Please write clearly.

Medical

Humana HMO HAS		Bi-Weekly
	Employee Only	$54.32
	Employee + SP	$108.64
	Employee + Child(ren)	$100.49
	Family	$193.01

Humana NPOS Opt 4		Bi-Weekly
	Employee Only	$54.72
	Employee + SP	$109.45
	Employee + Child(ren)	$101.23
	Family	$258.38

Humana NPOS Opt 12		Bi-Weekly
	Employee Only	$81.28
	Employee + SP	$187.44
	Employee + Child(ren)	$173.38
	Family	$371.06

Humana HMO Opt 2		Bi-Weekly
	Employee Only	$89.91
	Employee + SP	$204.71
	Employee + Child(ren)	$189.36
	Family	$395.67

☐ I Decline Medical Reason _____

Dependents To be on the Medical Coverage

Name _____ Date of Birth _____ SSN: _____

Gender _____ Relationship _____

Name _____ Date of Birth _____ SSN: _____

Gender _____ Relationship _____

Name _____ Date of Birth _____ SSN: _____

Gender _____ Relationship _____

Name _____ Date of Birth _____ SSN: _____

Gender _____ Relationship _____

By my signature below, I represent that all information on this application is correct. I direct my employer to deduct the amount of required contribution from my pay. I understand, and agree, that contributions will be taken out on a pre-tax basis subject to the IRS Section 125 Plan.

I understand that if I am waiving coverage now, I must experience a qualifying life event or wait until open enrollment next year to enroll. Requests for status changes must be submitted within 30 days of the qualified event.

_____

Employee Signature Date Signed