Open Enrollment Election Form

archcarebenefits@archcare.org

Please print and thank you for providing this information.

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.	HOME PHONE ( )	WORK PHONE ( )
ADDRESS *(Street)*		*(City)*		*(State)*	*(Zip Code)*

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	RELATIONSHIP	DEPENDENT'S SOCIAL SECURITY NO.	DATE OF BIRTH Mo. Day Year	GENDER	COVERAGE SELECTION	FULL TIME STUDENT?* Yes No
Employee	Self			M F	Medical Vision Dental	
Spouse*				M F	Medical Vision Dental	
Dependent *				M F	Medical Vision Dental	
Dependent*				M F	Medical Vision Dental	
Dependent *				M F	Medical Vision Dental	

* ***To enroll a spouse provide a copy of your marriage certificate; To Enroll Dependent child provide copy of birth certificate***

MEDICAL OPTIONS:

- ☐ Emblem Option 1 - No Wellness
- ☐ Emblem Option 1 with Wellness
- ☐ Waive Medical Coverage
- ☐ Emblem Option 2 - No Wellness
- ☐ Emblem Option 2 with Wellness
- ☐ Emblem Option 3 - No Wellness
- ☐ Emblem Option 3 with Wellness

VSP (VISION PLAN):

- ☐ YES
- ☐ Waive Vision Coverage

METLIFE (DENTAL OPTION):

- ☐ YES
- ☐ Waive Dental Coverage

Wellness Agreement

It is your choice to participate. or not participate in ArchCare's Wellness Program. Participation in the program entitles you to the wellness care member contribution rate, as well as a Health Reimbursement Account (HRA). Be advised that by electing to participatee in the Wellness Program, you are agreeing to meet the quarterly requirements as outlined by the program. Specifically, you are required to earn 250 points by the last day of each quarter (3/31, 6/30, 9/30, 12/31). Should you fail to meet the requirements of the program in a given quarter, your participation in the program will be discontinued. Effective the following quarter, your care member contributions will be increased tothe non-wellness rate, you will no longer be eligible to recevie HRA money, * and you will be required to pay back the difference in contribution (wellness/non-wellness) for the quarter in which you did not meet the requirement. *the difference in contribution will be calculated and deducted from your paychecks throughout the following quarter.

Salary Reduction Agreement

I hereby authorize ArchCare if necessary, to deduct the cost of coverage from my paychecks. I understand that the coverage I have elected will remain in force from January 1, 2024 to December 31, 2024, unless familiy status changes.

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE