PAYCHEX

Enroll online at https://paychexflex.com
Fax to: PBS Health & Benefits (800) 668-7296
Email to: PEO_benefitsteam@paychex.com

PBS Health and Benefits Universal Enrollment/Change Form

1. EMPLOYEE INFORMATION (Print using black or blue ink ONLY)

☐ Additional Page(s) (Please mark if more than 5 dependents)

EMPLOYEE NAME (Last, First, Middle Initial)	GENDER	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	
HOME ADDRESS	CITY		STATE	ZIP CODE
E-MAIL ADDRESS			CLIENT NAME/NUMBER	

2. TYPE OF ENROLLMENT OR CHANGE: Date of Event ___/___/___ (Check ALL that apply, attach applicable documentation*, and **return within 30 days of the event)**

☐ New Hire/New Client Onboarding ☐ Annual Enrollment ☐ Qualifying Event* ☐ Domestic Partner (DP) Life Event * ☐ Beneficiary Information

MEDICAL BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____ ***EE PCP#*** _____
☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse/DP ☐ Family ☐ **I waive medical coverage**

DENTAL BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____ ***EE PCD#*** _____
☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse/DP ☐ Family ☐ **I waive dental coverage**

VISION BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____
☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse/DP ☐ Family ☐ **I waive vision coverage**

ACCIDENT BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____
☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse/DP ☐ Family ☐ **I waive accident coverage**

CRITICAL INSURANCE BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____
☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse/DP ☐ Family ☐ **I waive critical care coverage**

HOSPITALIZATION BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____
☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse/DP ☐ Family ☐ **I waive hospitalization coverage**

PRE-PAID LEGAL BENEFITS ***Plan #*** _____ ***Plan Name/Description*** _____
☐ Employee ☐ **I waive pre-paid legal coverage**

EMPLOYEE LIFE INSURANCE BENEFITS - **Available in $10,000 increments up to 5x annual salary or $1 million whichever is less, evidence of insurability (EOI) may be required.**
☐ Amount _____ We may not **process your full enrollment until your election is approved by the carrier.** ☐ **I waive life coverage**

SPOUSE LIFE INSURANCE BENEFITS - Coverage available for the Employee's spouse/DP). Employee must be enrolled in a life product, may only have 50% of employee amount.
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ **I waive spouse life coverage**

CHILD(REN) LIFE INSURANCE – Coverage available for the Employee's child(ren) or for children of the Employee's Domestic Partner, may only have 40% of employee amount.
☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000 ☐ **I waive child(ren) life coverage**

3. DEPENDENTS COVERED For more than 5 dependents, attach additional *Enrollment/Change Forms*. **All information in this section is REQUIRED for processing.**

Enrollment Action	Plan Selection	Full Names of ALL Covered Dependents (LAST NAME, FIRST NAME, MIDDLE INITIAL)	Gender	Relationship	Date of Birth MM/DD/YYYY	Social Security Number (Required)	Medical Primary Care Physician (PCP Number)	Dental Primary Care Dentist (PCD Number)
☐Add ☐Change ☐Remove	☐Med ☐Acc ☐Den ☐Crt ☐Vis☐Hos☐SPI		☐M ☐F	☐Child ☐Spouse ☐DP ☐DP Child				
☐Add ☐Change ☐Remove	☐Med ☐Acc ☐Den ☐Crt ☐Vis☐Hos☐SPI		☐M ☐F	☐Child ☐Spouse ☐DP ☐DP Child				
☐Add ☐Change ☐Remove	☐Med ☐Acc ☐Den ☐Crt ☐Vis☐Hos☐SPI		☐M ☐F	☐Child ☐Spouse ☐DP ☐DP Child				
☐Add ☐Change ☐Remove	☐Med ☐Acc ☐Den ☐Crt ☐Vis☐Hos☐SPI		☐M ☐F	☐Child ☐Spouse ☐DP ☐DP Child				
☐Add ☐Change ☐Remove	☐Med ☐Acc ☐Den ☐Crt ☐Vis☐Hos☐SPI		☐M ☐F	☐Child ☐Spouse ☐DP ☐DP Child				

3a. If any dependent above lives at a different address than the Employee, provide the dependent's address and explain circumstances. Failure to provide this information could result in non-coverage of dependent(s). Domestic Partners and Domestic Partner's Children must reside with Employee.

_____

_____

4. BENEFICIARY INFORMATION You are automatically the beneficiary for your spouse and/or child(ren). When specifying multiple beneficiaries, you **must** indicate the percentage to be paid to each beneficiary. **For more than two beneficiaries, attach an additional** Enrollment/Change Form and check ☑ **Beneficiary Life Insurance Information.**

Beneficiary Name (Print Last, First, MI)	Address	Social Security Number	Date of Birth	Percentage

5. EMPLOYEE SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application.

SIGNATURE_____ **DATE**____/____/____

Please make a copy for your records.

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Instructions

Employee – Complete Sections 1-9. You will need your *Employee Benefits Statement* to complete this form.

Section 1 – Employee Information

Complete **all** information for your enrollment/change request to be processed without delays.

Section 2 – Type of Enrollment or Change

- * *Indicates supporting documentation required. For a list of required supporting documentation, refer to the PEO Qualifying Event Checklist or the Domestic Partner Life Event Checklist - PEO as applicable.
- Refer to your Employee Benefits Statement to determine which benefits are offered by your employer.
- Write the plan election in the spaces provided and select the level coverage.
- If waiving coverage, you must complete a waiver form for medical, dental and vision plans only.
- Basic Life and AD&D Insurance is paid by your employer. If offered, you automatically receive this benefit and the information will appear on your *Employee Benefits Statement*.
- **Voluntary Life Insurance**: If your employer does not offer Basic Life and AD&D, you can elect voluntary life insurance for yourself, your Spouse/Domestic Partner and/or Children or Children of your Domestic Partner. Refer to your *Carrier Benefit Summary* for cost.
- If you are electing life insurance coverage after your initial eligibility or in addition to your existing life coverage, you will have to provide Evidence of Insurability.

Section 3 – Dependents Covered

Complete **all** information for your enrollment/change request to be processed.

- Add/Change/Remove – to indicate whether you are adding, changing or removing coverage for an individual.
- Print all the covered dependents including your spouse/Domestic Partner(DP), child(ren) or children of the DP, if applicable. All information in this section must be completed for each individual listed.
- From the appropriate provider directory, locate the office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form (Medical=PCP ID#; Dental=Facility or PDP ID#).
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you or your Spouse/DP, DP child(ren) or dependent(s) have other health or prescription drug coverage, check the "Yes" box(es) and provide name and policy number of insurance carrier or other source of coverage in the space provided.
- If you have a disabled children(ren), attach the appropriate Carrier-required forms. Failure to provide the required documents could result in non-coverage of the dependent(s).

Section 4 – Beneficiary Information:

- Designate your beneficiaries for any life insurance provided and/or elected.

Section 5 – Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- You must sign and date this *Enrollment/Change Form* for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and those individuals eligible and listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, and signing the front of this enrollment form, coverage will be provided by the following entities (collectively referred to as "the insurance carrier(s)").
   - Medical
   - Dental
   - Vision
   - Life
   - Voluntary Benefits

   Coverage will not be effective unless and until the required supporting documentation is received timely by PBS.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. Accident Insurance
   - Benefit Election Disclosure
   - *Your Accident certificate provides limited benefits – read your certificate carefully. By enrolling for Accident Insurance, I declare that all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses; I acknowledge that I have received and read a copy of the outline of coverage or other disclosure document for the group Accident plan. In addition, I have read the enrollment documentation and declare that all information I have given is true and complete to the best of my knowledge and belief; I have read the applicable Fraud Warning(s) provided.*
4. Critical Illness Insurance
   - Benefit Election Disclosure
   - *Your Critical Illness certificate provides limited benefits – read your certificate carefully. By enrolling for Critical l Illness Insurance, I declare that no person proposed for Critical Illness coverage is covered under any Title XIX program (Medicaid or any similarly named program); that all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses; I acknowledge that I have received a Shopper's Guide to Cancer Insurance; and I have received and read a copy of the outline of coverage or other disclosure document for the group Critical Illness plan. In addition, I have read the enrollment documentation and declare that all information I have given is true and complete to the best of my knowledge and belief; I have read the applicable Fraud Warning(s) provided.*
5. Hospitalization Indemnity Insurance
   - Benefit Election Disclosure
   - *Your Hospital Indemnity certificate provides limited benefits – read your certificate carefully. By enrolling for Hospital Indemnity Insurance, I declare that all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses; I acknowledge that I have received and read a copy of the outline of coverage or other disclosure document for the group Hospital Indemnity plan. In addition, I have read the enrollment documentation and declare that all information I have given is true and complete to the best of my knowledge and belief; I have read the applicable Fraud Warning(s) provided.*
6. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate, etc.) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary, or other description of the plan, including the Summary Plan Description.

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PBS Health and Benefits
Acceptance/Refusal of Coverage

EMPLOYEE INFORMATION (print) **All eligible employees must complete, sign and return this form.**

Employee Name_____ Social Security Number_____ DOB (mm/dd/yyyy) _____

Acceptance of Coverage:
I am electing coverage in the following benefits.
(check ALL that apply)

☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Pre-Paid Legal
☐ Accident ☐ Hospital Plan ☐ Critical Care

Refusal / Waiver of Coverage ***(see below for required refusal/waiver information)***
I am waiving coverage or requesting termination for the following benefits*:
(check ALL that apply)

☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Pre-Paid Legal
☐ Accident ☐ Hospital Plan ☐ Critical Care

Refusal / Waiver of Coverage
The reason I am waiving coverage or requesting termination of my PBS medical plan enrollment is: (check one)

☐ I am covered under an individual health plan.*
☐ I am covered under another group health plan offered to my spouse/ domestic partner.*
☐ I am covered under another group health plan offered by my Employer.*
☐ I am covered under another group health plan offered by the Military.*
☐ I am covered under Medicare.*
☐ I am covered under Medicaid.*
☐ I am covered through my parents group health plan.*
☐ I am covered through the Marketplace.*
☐ I do not have any dependents that need or require coverage.
☐ The plan(s) is (are) too expensive.
☐ I am declining coverage for other reasons.
Specify _____

*Medical Carrier_____ *Policy Number_____

PAYCHEX ACKNOWLEDGE INFORMATION

I acknowledge receipt of the PAYCHEX BUSINESS SOLUTIONS, INC. (PBS) FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION AND PEO EMPLOYEE BENEFITS SUMMARY PLAN DESCRIPTION. I understand that if I do not elect benefits at the time of my initial eligibility, I will not be permitted to enroll at a later date, or make any changes unless a qualifying event or domestic partner life event occurs. I also understand that if I do elect benefits upon initial eligibility, I will not be able to terminate coverage, or make any changes unless a qualifying event or domestic partner life event occurs, or until Annual Enrollment. I understand if I experience a qualifying event or domestic partner life event and would like to enroll or make any changes to my benefit elections, I must notify PBS and submit evidentiary documentation within thirty (30) days of my qualifying event or domestic partner life event. If these procedures are not followed, I will not be permitted to enroll or to make changes until the following Annual Enrollment period. I understand that the authorized changes must be consistent with the reason that such change was permitted.

I understand the Internal Revenue Service defines "Qualifying Events" as follows:

- marriage (as defined by federal law), divorce, or legal separation
- birth or adoption of dependent
- dependent reaches ineligible age or status
- death of spouse or dependent
- eligibility (or ineligibility) for Medicare/Medicaid
- termination or commencement of employee or spouse's employment
- employee or spouse takes unpaid leave of absence
- significant change in employee or spouse's health coverage
- employee or spouse's employment status changes from full-time to part-time (or vice-versa)

For a definition of domestic partner life event, I can refer to the Domestic Partner Life Event Checklist (PHB364). I also understand that the list above may be subject to change and limited in scope based on eligibility. PBS reserves the right to interpret the rules for administering pretax benefit plans, outlined in Section 125 of the Internal Revenue Code, as they deem appropriate. These rules will be applied consistently to all participants in any PBS-sponsored group benefit plan.

In addition, I understand that should I separate from my employment for any reason, my current elections will continue through the end of the month during which PBS receives notification of my separation. My share of the premiums for this period may be satisfied by payroll deductions from my final paycheck.

LATE ENROLLEES

1. **Other Employer Health Benefit Plan Coverage**. You and your dependents (collectively "you") shall not be considered late enrollees if you meet each of the following requirements:
   a) You are covered under another employer health benefit plan ("Plan"), although you are also eligible to enroll in a PBS Benefit Plan;
   b) You certify in writing on this *Acceptance or Refusal of Coverage* form, that you are declining PBS Benefit coverage because you are already covered under another group plan;
   c) You learn at a later date that you have lost or will lose coverage under the other plan because of:
      1) the termination of your employment or the employment of the person through whom you are covered as a dependent;
      2) a change in your employment status or the employment status of the person through whom you are covered as a dependent;
      3) the termination of coverage under the other plan;
      4) the death of the person through whom you are covered as a dependent; or
      5) the divorce from the person through whom you are covered as a dependent; and
   d) You request enrollment within 30 days after the termination of your coverage under the other plan due to the reasons stated above in subsection (c).
2. **Multiple Plans**. If your employer offers multiple health plan options under the PBS Benefit Plan, and you enrolled in one of such plans during a previous enrollment period, you will not be classified as a late enrollee if you decide to change plans and enroll in another plan, during open enrollment, for the following plan year.
3. **Court Order**. If a court has ordered that you obtain health care coverage for your minor child, you must submit an application for enrollment within 30 days after issuance of the court order for yourself and minor child. All benefits commerce first of the following month and terminated the last day of the month.

I understand that in the event I and/or my eligible dependents choose to enroll in a PBS Benefit Plan at a later date, we may be considered "late enrollees" and may have to wait for coverage for a period of up to 12 months to enroll. I understand that if ONE of the THREE circumstances set forth above apply to us, we will not be considered late enrollees, and thus, will not have to wait for a period of up to 12 months to enroll in a PBS Plan.

Employee Signature_____ Date____/____/____