FIELD EMPLOYEES
Complete This Entire Form – All 5 Pages

2015 Enrollment/Change Form
HACI Mechanical Contractors, Inc.

❑ New Employee (complete entire form) ❑ Open Enrollment ❑ Birth / Adoption

❑ Address Change ❑ Marriage ❑ Spouse change in coverage ❑ Death of Dependent ❑ Divorce / Legal Separation ❑ Other

Employee Information

Effective Date or Date of Change_____

Name _____ (Last) _____ (First) _____ (MI) _____ (SSN)

Mailing Address _____ (Street) Date of Hire _____ (mm/dd/yyyy)

_____ (City) _____ (State) _____ (Zip) Date of Birth _____ (mm/dd/yyyy)

Home Phone _____ Sex ❑ Male ❑ Female Marital Status ❑ Married ❑ Single

Work Phone _____ Date of Marriage _____

Annual/Hourly Rate $_____ ❑ Hourly ❑ Salaried Hours Scheduled to Work Per Week _____ hours per week

Email:_____.

To WAIVE all coverages except employer paid life, please select this option. ❑ **Waive Coverage**

Instructions

This enrollment form is designed to help you enroll in the HACI Mechanical Contractors, Inc. Health and Welfare Benefit Plan. Before completing the enrollment form, you should review all enrollment information carefully and determine, for each plan, which option and level of coverage best meets your needs. Record the option selected in the spaces provided. Your completed enrollment form should then be forwarded to Human Resources.

Enrollee Information: Please indicate which plan(s) the members are being enrolled in:

M – Medical; D – Dental; V-Vision

Med, Dental and/or Vision	Spouse or Child	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Sex	SSN
☐ M ☐ D ☐ V	Self				
☐ M ☐ D ☐ V	☐ S ☐ C			☐ M ☐ F	
☐ M ☐ D ☐ V	☐ S ☐ C			☐ M ☐ F	
☐ M ☐ D ☐ V	☐ S ☐ C			☐ M ☐ F	
☐ M ☐ D ☐ V	☐ S ☐ C			☐ M ☐ F	
☐ M ☐ D ☐ V	☐ S ☐ C			☐ M ☐ F	

Medical (check the box for the options you elect)

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive Coverage	Reason for Waiving
Aetna OAMC weekly →	❑ $16.73	❑ $94.61	❑ $63.46	❑ $167.30	❑	
(non-Banner) (monthly)	$72.50	$410.00	$275.00	$725.00		
Aetna Banner OAMC weekly →	❑ $2.31	❑ $61.16	❑ $35.77	❑ $121.16	❑	
(monthly)	$10.00	$265.00	$155.00	$525.00		

1. I understand that coverage is being provided by the following companies:
   Traditional Choice®, Open Choice® and Managed Choice®: Aetna Life Insurance Company
   Life, Accidental Death & Personal Loss, Disability: Aetna Life Insurance Company
   HMO, QPOS®: Aetna Health Inc., Aetna Health Of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Corporate Health Insurance Company
   Dental: Aetna Life Insurance Company, Aetna Health Inc., Aetna Dental Inc., Aetna Dental of California Inc.

2. The plan documents (Schedule of Benefits, Group Agreement, Group Policy, and Certificate of Coverage) will determine my rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan.

3. I understand and agree that with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular product cannot be guaranteed and provider network composition is subject to change.

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dental Insurance (Check the box for the options you elect)

	Weekly Cost				
	Employee Only	Employee + One	Employee + 2 or more	Waive Coverage	Reason for Waiving
Dental Co-Pay → SecureCare Dental	❑ $3.02	❑ $5.68	❑ $8.63	❑ $0	
Dental PPO → SecureCare Dental	❑ $5.31	❑ $9.57	❑ $14.30	❑ $0	
Dental Indemnity → SecureCare Dental	❑ $7.83	❑ $14.63	❑ $22.33	❑ $0	

The above deductions will be made on a pre-tax basis if you choose. This election form will remain in effect and cannot be revoked or changed during this plan year unless the revocation and new election are on account of, and consistent with, a change in family status (e.g., marriage, divorce, death of a dependent, birth or adoption of a child, change in work status for yourself or your spouse or significant change in coverage or cost of the plan).

Vision (check the box for the option you elect) AMOUNTS BELOW ARE WEEKLY

	Weekly Cost				
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive Coverage
Vision → EyeMed	❑ $1.64	❑ $3.10	❑ $3.26	❑ $4.80	❑ $0

The above deductions will be made on a pre-tax basis if you choose. This election form will remain in effect and cannot be revoked or changed during this plan year unless the revocation and new election are on account of, and consistent with, a change in family status (e.g., marriage, divorce, death of a dependent, birth or adoption of a child, change in work status for yourself or your spouse or significant change in coverage or cost of the plan).

Employee Supplemental Life Insurance – AETNA

❑ **Enroll in Employee Supplemental Life** ❑ **Decline Employee Supplemental Life**

Increments of $10,000 up to 5 times annual earnings or $500,000. Guarantee issue at eligibility $150,000.

Select Coverage Amount → $ _____

Coverage Amount (from above)		**Employee Rate per $1,000 of Coverage** (see rate table below)			Weekly Cost of Option Elected
$ _____	÷ **1,000 X**	$ _____	X 12 ÷ 52 =		$

Any amounts over guarantee issue require an evidence of insurability form. See Human Resources for form if electing more than $150,000.
The above deduction will be made on an after-tax basis.

Spouse Supplemental Life Insurance – AETNA

(enter spouse life insurance coverage amount or $0 to waive coverage)

❑ Enroll in Spouse Life ❑ **Decline Spouse Supplemental Life**

Select Coverage Amount:
Enter in $5,000 increments up to 100% of the employee's elected supplemental coverage not to exceed $100,000. Guarantee issue at eligibility $50,000.

→ $ _____ | Spouse Rate Based on Employee Age

Note: To be eligible for spouse coverage, at least $10,000 of Employee Supplemental Life Insurance must be elected.

Coverage Amount (from above)		**Spouse Rate per $1,000 of Coverage** (see rate table below)			Weekly Cost of Option Elected
$ _____	÷ **1,000 X**	$ _____	X 12 ÷ 52 =		$

Any amounts over guarantee issue require an evidence of insurability form. See Human Resources for form if electing more than $50,000.
The above deduction will be made on an after-tax basis.

Supplemental Employee / Spouse Life Insurance Rate Table

Age of Covered Employee	Monthly Rate Per $1,000 of Coverage	Age of Covered Employee	Monthly Rate Per $1,000 of Coverage
<25	$0.078	50-54	$0.359
25-29	$0.091	55-59	$0.710
30-34	$0.099	60-64	$0.949
35-39	$0.123	65-69	$1.560
40-44	$0.151	70-74	$2.760
45-49	$0.229	75+	$4.420

Child(ren) Supplemental Life Insurance – AETNA

(enter child(ren) life insurance coverage amount or $0 to waive coverage)

Select Coverage Amount:
$5,000 or $10,000. → $ _____

Note: To be eligible for child(ren) coverage, at least $10,000 of Employee Supplemental Life Insurance must be elected.

$0.65 for $5,000 and $1.30 for $10,000 per month per Family Unit X 12 ÷ 52 =

Weekly Cost of Option Elected: $

The above deduction will be made on an after-tax basis.

Voluntary Short-Term Disability – AETNA
(70% of weekly wages to a $750/week maximum benefit – 26 week benefit)

Select → ❑ Yes I want to enroll for the weekly disability income coverage ❑ No I do not want to enroll for the weekly disability income coverage

Cost and Benefit of STD

Hourly Wage: $_____ Hourly base wage as of January 1st of the current plan year.
Salaried employees: Annual Salary ÷ 2080 = Hourly Wage

Calculation:

_____	X	40	=	_____			
Hourly Wage		Hours/Week		Weekly Salary			
_____	X	_____	=	_____	X 12 ÷ 52	_____	
Weekly Salary		Rate (See rate table below)		Employee Cost/Month		Employee Cost Weekly	

The above deduction will be made on an after-tax basis

Voluntary Short-Term Disability Rate Table

Age of Covered Employee	Premium Factor	Age of Covered Employee	Premium Factor
<25	$0.0350	50-54	$0.0553
25-29	$0.0266	55-59	$0.0749
30-34	$0.0322	60-64	$0.0896
35-39	$0.0357	65-69	$0.0980
40-44	$0.0350	70+	$0.01113
45-49	$0.0420		

Voluntary Long-Term Disability – AETNA
(60% of monthly wages to a $5,000/month maximum benefit – 180 day elimination period)

Select → ❑ Yes I want to enroll for the long-term disability income coverage ❑ No I do not want to enroll for the long-term disability income coverage

Cost and Benefit of LTD

Monthly Wage: $_____ Monthly base wage as of January 1st of the current plan year.
Salaried employees: Annual Salary ÷ 12 = Monthly Wage
Hourly employees: Hourly Wage x 2080 / 12 = Monthly Wage

Calculation:

_____	X	_____	=	_____	X 12 ÷ 52	_____	
Monthly Wage		Rate (See rate table below)		Employee Cost/Month		Employee Cost Weekly	

The above deduction will be made on an after-tax basis

Voluntary Long-Term Disability Rates

Age of Covered Employee	Premium Factor	Age of Covered Employee	Premium Factor
<25	$0.00072	50-54	$0.00576
25-29	$0.00081	55-59	$0.00891
30-34	$0.00099	60-64	$0.01206
35-39	$0.00171	65-69	$0.00675
40-44	$0.00243	70+	$0.00342
45-49	$0.00405		

aetna®

Aetna Life Insurance Company
Designation of Beneficiary

Before executing this form refer to other side. Please keep a copy for your records.

Group Policyholder Name	Group Policy Number
HACI MECHANICAL CONTRACTORS, INC.	804539

Employee/Retiree Name and Address	Employee/Retiree Social Security Number
	Employee/Retiree Date of Birth
	Employee/Retiree Phone Number

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all elections of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages. This Designation of Beneficiary is subject to all "Conditions" shown on the reverse side of this form.

Employee/Retiree Signature	Date

Beneficiary Name and Address ☒ **Primary Beneficiary***

Relationship	Phone Number	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address (Please check one) ☐ **Primary Beneficiary*** *or* ☐ **Contingent Beneficiary****

Relationship	Phone Number	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address (Please check one) ☐ **Primary Beneficiary*** *or* ☐ **Contingent Beneficiary****

Relationship	Phone Number	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address (Please check one) ☐ **Primary Beneficiary*** *or* ☐ **Contingent Beneficiary****

Relationship	Phone Number	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

*If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. If two or more primary or contingent beneficiaries are named, enter the percentage each beneficiary is to receive in the space provided, primary and contingent beneficiaries should both equal 100%.
**Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY - See Conditions on reverse side of form.

Please note that an employee/retiree is under no obligation to complete the Spousal Consent section of this form.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature ______________________________ Date ________________

I hereby authorize and direct my employer, HACI Mechanical Contractors, Inc. to reduce my salary in the amount necessary to pay for the coverages I have elected. I further authorize future additional reductions in the event that the cost of coverage in any program selected is increased during the plan year.

This election form will remain in effect and cannot be revoked or changed during the Plan Year unless a revocation and new election are due to and consistent with a change in family status (e.g. Marriage, divorce, death of spouse, birth or adoption of child), change in work status for yourself or your spouse or significant change in coverage or cost of the plan.

Waiver (Refusal of coverage): I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by me employer, the writing agent or Aetna into waiving (declining) coverage. If I have waived any coverage offered to me and my dependents, my signature below is evident of this action. I have check marked NO above for any items I do not desire.

I understand and agree:

In the event that I should decide to apply for such coverage, hereafter, that such subsequent application shall be subject to applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional imitations and waiting periods.

If I am declining coverage for myself or my dependents, provided that I request enrollment within 30 days after my other coverage ends.

If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself or my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Signature:_____ Date:_____