OUTPATIENT MEDICAL CENTER
BENEFIT ELECTION FORM
OCTOBER 2017 – SEPTEMBER 2018

BCBS: 78C83ERC
KCL: 21753

ADMINISTERED BY:

HPL Benefits Inc.

LOCATION: LEESVILLE - NATCHITOCHES - TALLULAH **JOB TITLE:**

HOURS PER WEEK: 30+ **BENEFIT ELIGIBLE DATE:**

THIS ENROLLMENT IS: ☐ NEW HIRE ☐ CHANGE ☐ OPEN ENROLLMENT

NAME: _____
LAST NAME *FIRST* *MIDDLE*

HOME ADDRESS: _____
STREET (INCLUDING APT #) *CITY* *STATE* *ZIP*

PHONE: _____ **EMAIL:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

GENDER: ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED

BENEFIT ELECTIONS

- EMPLOYEE COSTS SHOWN ARE ***BASED ON 24 PAY PERIODS*** – THIS IS THE AMOUNT AFTER THE EMPLOYER CONTRIBUTION IS DEDUCTED
- MEDICAL, DENTAL, AND VISION COSTS ARE DEDUCTED PRE-TAX
- PLEASE SEE BENEFIT SUMMARIES FOR ADDITIONAL INFORMATION, EXCLUSIONS, LIMITATIONS, & QUALIFICATIONS

MEDICAL COVERAGE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
BCBS 80/60 $1,000 DEDUCTIBLE	☐ $76.22	☐ $457.32	☐ $400.18	☐ $781.29
BCBS 90/70A $0 DEDUCTIBLE	☐ $133.02	☐ $570.91	☐ $505.26	☐ $943.16

☐ I DO NOT WANT MEDICAL COVERAGE (WAIVER)

DENTAL COVERAGE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
	☐ $14.19	☐ $31.88	☐ $27.36	☐ $45.56

☐ I DO NOT WANT DENTAL COVERAGE (WAIVER)

VISION COVERAGE

EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
☐ $2.66	☐ $4.79	☐ $5.05	☐ $7.98

☐ I DO NOT WANT VISION COVERAGE (WAIVER)

GROUP LIFE INSURANCE OF $15,000 IS 100% EMPLOYER PAID

PRIMARY BENEFICIARY_____ RELATIONSHIP_____

CONTINGENT BENEFICIARY_____ RELATIONSHIP_____

DEPENDENT INFORMATION FOR ALL COVERAGE (YOU MUST INCLUDE ALL INFORMATION)

1. A SPOUSE IS DEFINED AS SOMEONE WHO IS LEGALLY MARRIED TO YOU. DOMESTIC PARTNERS DO NOT QUALIFY
2. ELIGIBLE CHILDREN ARE THOSE WHO ARE UNDER THE AGE OF 26 AND ARE LEGAL DEPENDENTS OF YOU.
3. CONTACT HPL BENEFITS AT 318-226-0500 IF YOU NEED TO ENROLL MORE THAN FOUR CHILDREN

	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SSN	GENDER
SPOUSE						
CHILD#1						
CHILD#2						
CHILD#3						
CHILD#4						

Blue Cross Blue Shield of Louisiana - Coverage Conditions:

I, the undersigned, do hereby enroll for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNLIC) for myself and any family members listed on this enrollment form. I understand that this enrollment/change form, together with the certificate of coverage, any riders and endorsements issued by Companies, constitute my only agreement with Companies. I understand that the contract as it pertains to me and my dependent(s) will be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if I committed fraud or made an intentional misrepresentation of material fact in this enrollment/change form. I further understand that if enrolled for coverage with Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. or Southern National Life Insurance Company, Inc. that the contract issued by either company constitutes a contract solely between that company and the group/policy holder and that Blue Cross Blue Shield of Louisiana, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. are all independent corporations operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the "Association" permitting the individual companies to use the Blue Cross and Blue Shield service marks in the state of Louisiana and that the companies are not contracting as an agent of the Association. I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for coverage(s), to give the information to Companies or any agent acting on Companies' behalf. I understand this information will be used by the companies to determine eligibility or other related decisions deemed necessary for insurance coverage. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the health coverage provided from time to time by my employer's group health plans, and I authorize deduction from my pay the amounts, if any, as may be necessary. The information given on this application is true and correct to the best of my knowledge and belief. I understand that if I am declining enrollment for myself or my Dependents (including spouse), I may in the future be able to enroll myself or my Dependents in these plans, provided that I request enrollment within 30 days of the qualifying event. In addition, if I have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, I may be eligible to enroll myself or my Dependents provided that I request enrollment within 30 days after the marriage, birth adoption or placement for adoption. I acknowledge if I am eligible for Medicare, by reason of age, I have received a copy of "The Guide to Health Insurance for People with Medicare." It is a dependent's responsibility to apply for continuous coverage on a separate contract /certificate when eligibility ceases.

Fraud Statement:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison. All of the questions in this application and in the health history section have been read by or to me and the answers provided by the enrollee and/or Dependent(s) if any, are true and correct to the best of my knowledge and belief.

Salary Reduction Agreement - Section 125 Plan:

I have read and understand the explanation I have received regarding my options under the Outpatient Medical Center premium only plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. 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 me, my spouse or children; or my dependent 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. It is specifically the participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. I hereby apply for the options listed above. If necessary, I authorize Outpatient Medical Center to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from the effective date until September 30th, unless my family status changes.

I have received a copy of the current SBC (Summary of Benefits and Coverage)

Acknowledgement of the Outpatient Medical Center Summary Plan Description:

Each plan participant must acknowledge their receipt of the Welfare Benefit Plan Summary Plan Description. By signing below, I acknowledge receipt of the Outpatient Medical Center Welfare Benefit Plan Summary Plan Description.
This document also includes my initial COBRA notice as mandated by law.

EMPLOYEE SIGNATURE _____ **DATE** _____

OMC
Outpatient Medical Centers, Inc.
Providing Quality Healthcare To All.