Employee Enrollment / Change Form

☐ Open Enrollment
☐ New Employee
☐ Qualifying Event

MOCA

Employer

Employer Name			Employee Job Location	
Missouri Ozarks Community Action				
Employee Date of Hire / /	Coverage Effective Date / /	Earnings	Hours Worked Weekly	Job Title

Employee

Name: Last	First	M.I.	Home Phone Number ( )
Address	City	State	Zip
Date of Birth / /	Gender	Marital Status	Social Security Number

Elections

☐ I am making no changes to my benefits this year, please carry over current elections. (You do not need to fill out elections below)

Medical Base	Medical Middle	Medical Buy Up	Dental Base	Dental Buy Up
☐ Employee	☐ Employee	☐ Employee	☐ Employee	☐ Employee
☐ Employee & Spouse	☐ Employee & Spouse	☐ Employee & Spouse	☐ Employee & Spouse	☐ Employee & Spouse
☐ Employee & Child(ren)	☐ Employee & Child(ren)	☐ Employee & Child(ren)	☐ Employee & Child(ren)	☐ Employee & Child(ren)
☐ Family	☐ Family	☐ Family	☐ Family	☐ Family
☐ Waive	☐ Waive	☐ Waive	☐ Waive	☐ Waive

Voluntary Vision
☐ Employee
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Family
☐ Waive

☑ **Employer Paid Basic Life, $20,000**
Please Note: All Employees must complete the Beneficiary Designation section.

Currently have Medical Insurance ☐ Yes ☐ No
Currently have Medicare Insurance ☐ Yes ☐ No

Voluntary Life Amount*	Matching Voluntary AD&D	Guaranteed Issue for Voluntary Life**
☐ Employee _____	☐ Employee	Employee $130,000
☐ Spouse _____	☐ Spouse	Spouse $50,000
☐ Child(ren) _____	☐ Child(ren)	Child(ren) $10,000
☐ Waive All	☐ Waive All	

*If electing more coverage than the guaranteed issue amount, Evidence of Insurability (EOI) form must also be submitted with application

**Guaranteed issue amounts only apply to employees during initial eligibility period. Late entrants will need to submit an EOI for amounts over $20,000. A late entrant is anyone who did not apply for Voluntary Life Insurance when first eligible.

Waiving Coverage

Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes.

☐ **CERTIFICATION:** I freely and voluntarily waive all coverage noted above for myself and my family. I fully understand that I will not be eligible to enroll into plans until Open Enrollment January 1, 2020, unless I experience a Qualifying Event.

_____ Employee SIGNATURE

_____ DATE

Beneficiary Designation

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary:

Last Name	First Name	MI	Percentage:	Relationship:	SSN:	Phone:
Last Name	First Name	MI	Percentage:	Relationship:	SSN:	Phone:

Contingent Beneficiary:

Last Name	First Name	MI	Percentage:	Relationship:	SSN:	Phone:
Last Name	First Name	MI	Percentage:	Relationship:	SSN:	Phone:

If electing any coverage for any dependents, you must complete the dependent information section below.

	Last Name	First Name	MI	Social Security #	Gender	Date of Birth	Medical	Dental	Vision
Spouse				/ /		/ /			
Children				/ /		/ /			
Children				/ /		/ /			
Children				/ /		/ /			
Children				/ /		/ /			
Children				/ /		/ /			

COMPLETE THIS SECTION IF MAKING COVERAGE CHANGES OFF OF ANNUAL OR INITIAL OPEN ENROLLMENT

Qualifying Event

Effective date of change: _____ **PLEASE SPECIFY APPROPRIATE QUALIFYING EVENT.**

Life Events

- ☐ Marriage
- ☐ Birth of a Child
- ☐ Adoption
- ☐ Other: _____

Loss of Coverage Due to

- ☐ Termination of employment
- ☐ Reduction in hours worked
- ☐ Death
- ☐ Cessation of employer contributions
- ☐ Other: _____

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that my deductions will be taken pre-tax and I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. Should I choose to have my deductions taken Post-Tax I must notify payroll prior to December 13th, 2019.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____ _____

Employee SIGNATURE DATE