THE Contractors Plan
Powered by Fringe Benefit Group

# GEMINI TECH EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

## TO BE COMPLETED BY THE EMPLOYEE

## EMPLOYEE INFORMATION

| | | | |
|---|---|---|---|
| *Employer Name* GEMINI TECH SERVICES, INC | | | |
| *Employee Last Name* | *Employee First Name* | *MI* | |
| *Date of Birth* / / | *Social Security Number* - - | *Gender* ◯ Male ◯ Female | *Base Salary* $ , |
| *Street Address* | | *Date of Hire* / / | |
| *City* | *State* | *Zip Code* - | |
| *Email* | *Phone* - | | |

## BENEFIT SELECTION

| | | | | | |
|---|---|---|---|---|---|
| **Major Medical EPO 8000 Core** | ◯ Employee Only | ◯ Employee + Spouse | ◯ Employee + Children | ◯ Family Coverage | ◯ N/A - Decline Coverage |
| **Major Medical PPO 6029 Buy Up** | ◯ Employee Only | ◯ Employee + Spouse | ◯ Employee + Children | ◯ Family Coverage | ◯ N/A - Decline Coverage |
| **Dental – PPO** | ◯ Employee Only | ◯ Employee + Spouse | ◯ Employee + Children | ◯ Family Coverage | ◯ N/A - Decline Coverage |
| **Vision** | ◯ Employee Only | ◯ Employee + Spouse | ◯ Employee + Children | ◯ Family Coverage | ◯ N/A - Decline Coverage |
| **EAP** | ◯ Employee Only | ◯ Employee + Spouse | ◯ Employee + Children | ◯ Family Coverage | ◯ N/A - Decline Coverage |
| **Life/AD&D** | ◯ Employee Only | **Benefit is mandatory for Full-Time Employees** | | | |
| **Short-Term Disability** | ◯ Employee Only | **Benefit is mandatory for Full-Time Employees** | | | |
| **Long-Term Disability** | ◯ Employee Only | **Benefit is mandatory for Full-Time Employees** | | | |

**Note: If you are declining Major Medical coverage, you must complete the waiver form and provide proof of other major medical insurance from your spouse's employer, VA Service Connected Medical Coverage, or Tricare Coverage. Your waiver will not be accepted without a completed & signed waiver form and proof of other valid coverage.** Employee Only coverage is paid for by your employer's H&W contribution. If you choose to elect dependents to your coverage, these costs will be payroll deducted.

**Specialty Benefits Include:** MetLife Dental, MetLife Vision, (EAP) Employee Assistance Program, MetLife Short-Term & Long-Term Disability, and MetLife Life/AD&D.

## LIFE INSURANCE BENEFICIARY INFORMATION

Beneficiary Designation

| | | | |
|---|---|---|---|
| *Primary Beneficiary Last Name* | *Primary Beneficiary First Name* | *MI* | *Relationship* |
| *Contingent Beneficiary Last Name* | *Contingent Beneficiary First Name* | *MI* | *Relationship* |

## DEPENDENT INFORMATION

Do you wish to cover your eligible dependents? ◯ Yes ◯ No If yes, complete the following:

| | | |
|---|---|---|
| *Spouse/Domestic Partner Last Name* | *Spouse/Domestic Partner First Name* | *MI* |
| *Date of Birth* / / | *Social Security Number* - - | *Sex* ◯ Male ◯ Female |
| *Child Last Name* | *Child First Name* | *MI* |
| *Date of Birth* / / | *Social Security Number* - - | *Sex* ◯ Male ◯ Female |
| *Child Last Name* | *Child First Name* | *MI* |
| *Date of Birth* / / | *Social Security Number* - - | *Sex* ◯ Male ◯ Female |
| *Child Last Name* | *Child First Name* | *MI* |
| *Date of Birth* / / | *Social Security Number* - - | *Sex* ◯ Male ◯ Female |
| *Child Last Name* | *Child First Name* | *MI* |
| *Date of Birth* / / | *Social Security Number* - - | *Sex* ◯ Male ◯ Female |

☐ *I would like to cover additional eligible dependents* (PLEASE LIST ON A SECOND ENROLLMENT FORM)

## EMPLOYEE STATEMENTS AND AGREEMENTS

I understand the effective date of coverage will be determined by the terms and eligibility requirements of the Master Policy.
I understand that changes to my Benefit Selections can only be made following a Qualifying Life Event.
I authorize deductions from my earnings at the required contributions towards the cost of the coverage.
I certify that I am eligible to participate and that the above information is correct.

| | |
|---|---|
| *Signature* | *Date* |

## TO BE COMPLETED BY THE EMPLOYER

| | | | |
|---|---|---|---|
| ◯ **New Enrollment** | ◯ **Add** ☐ Dependent(s) | ◯ **Change** ☐ Address ☐ Phone ☐ Name ☐ Cobra | ◯ **Cancel Coverage** ☐ Policy Holder ☐ Dependent(s) |

*Reason for Change*

☐ Employment Status
☐ Qualifying Event: (PLEASE STATE EVENT AND ATTACH PROOF) _____

A Qualifying Life Event (QLE) is a term defined by the IRS to describe events that may allow participants to change their benefit elections outside of an Open Enrollment period. Examples include: a change in family status that results in an increase or decrease in number of eligible family members, including, but not limited to: adoption, birth, marriage or divorce and death.

| | |
|---|---|
| *Requested Effective Date* / / | *Date of Employment* / / |