HealthPartners®

MEDICAL ENROLLMENT FORM

8170 33rd AVENUE SOUTH, PO BOX 297
MINNEAPOLIS, MN 55440-0297

NAME OF EMPLOYER: Scott County		GROUP NUMBER: 2604	SITE
EMPLOYEE STATUS ❑ Active / New hire ❑ Retired ❑ COBRA	EVENT STATUS ❑ OPEN ENROLLMENT ❑ LIFE EVENT Reason: ____________ ____________ ____________	❑ LATE ENROLLMENT Continuous medical coverage If YES, number of months:________ Coverage End Date: ________	HIRE DATE: ___/___/ 20 COVERAGE EFFECTIVE DATE: ___/___/ 20

APPLICANT: COMPLETE ALL UNSHADED AREAS

APPLICANT'S LAST NAME (LEGAL NAME) DATE OF BIRTH ___/___/_____

FIRST NAME M.I. ❑ SINGLE ❑ MARRIED

STREET ADDRESS / APT NUMBER CITY STATE

ZIP CODE COUNTY APPLICANT'S PHONE MOBILE HOME OTHER

MEDICAL PLAN SELECTED: ❑ HP Open Access Base Plan ❑ Waive Coverage

TIER SELECTED: ❑ Single ❑ Single +Spouse ❑ Single +Children ❑ Family

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EMPLOYEE AND EACH DEPENDENT BEING COVERED

NAME	SOCIAL SECURITY NUMBER	DISABILITY* (Y/N)	DATE OF BIRTH (M/D/YYYY)	RELATIONSHIP TO EMPLOYEE	SEX (M/F)	MEDICAL CLINIC# (For Primary Clinic Plans only)
				SELF		

Federal Medicare legislation now requires this information. If you have questions, contact Member Services.

Do any of the dependent(s) listed above reside at a different address from the applicant?

❑ YES ❑ NO If YES, list dependent(s) name and address: ____________________

At the time of your effective date with HealthPartners, will you, your spouse, and/or dependent(s) be insured by any other health insurance company?

❑ YES ❑ NO If YES, please complete the Coordination of Benefits Form. Check which type: ❑ Group ❑ Individual

How long has that applicant been with that insurer? Please list all:

APPLICANT	NAME OF INSURER	COVERAGE DATES
		TO
		TO
		TO
		TO

CONDITIONS OF COVERAGE:

I HEREBY APPLY FOR COVERAGE ON THE BASIS OF THE STATEMENTS AND ANSWERS TO THE QUESTIONS HEREIN. I hereby declare all answers to be true and complies with the best of my knowledge.

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) from my wages. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this Enrollment Form, I authorize HealthPartners, and others it designates, to share information about me with any medical provider, plan sponsor, or other entity, where such information is reasonably necessary for treatment, payment or health care operations. I understand that HealthPartners may release information regarding services provided under my health benefits contract when requested by the organization sponsoring my benefits plan.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS, CANCELLATION OR RECISSION OF COVERAGE.

SIGNATURE OF EMPLOYEE (required) **DATE SIGNED** **SIGNATURE OF EMPLOYER (optional)** **DATE SIGNED**

The HealthPartners family of health plans are underwritten and/or administered by HealthPartners, Inc., Group Health, Inc., HealthPartners Insurance Company or HealthPartners Administrators, Inc. Fully insured Wisconsin plans are underwritten by HealthPartners Insurance Company.

401025 (6/13) Scott County © 2013 HealthPartners

Delta Dental of Minnesota

Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last	First	Middle Initial	**Social Security Number** / /
Gender:	Male ☐ Female ☐	**Marital Status:**	Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address	Home Phone Number ( )	Work Phone Number ( )	
	City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who is Being Enrolled – Check One Box Only
*If waiving coverage for employee and/or eligible family members, complete Part B & D.

☐ Employee only* ☐ Employee and Child(ren)
☐ Employee and Spouse ☐ Family ☐ No Coverage*

PART C – DEPENDENT INFORMATION

Relationship To Employee	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Employee's)	**Gender**		**Date of Birth** Month/ Day/Year
Spouse		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

PART D – OTHER INSURANCE COVERAGE

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: ______________________ Policy/Identification No.: ______________

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: **Date:**

PART E – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: **Date:**

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Hire**	☐ **Open Enrollment**	☐ **Loss of Coverage**
Effective Date: ______ /______ /______ Hire Date: ______ /______ /______	Effective Date: ______ /______ /______	Qualifying Event Reason: ______________ Event Date: _______ /_______ /_______ Effective Date: _______ /_______ /_______

Group Name: Scott County	**Group & Subgroup Number:** 3014
Payroll Rep's Signature:	**Date of Entry:**

Benefits Enrollment Form for SCOTT COUNTY
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION		
Name (FIRST MI LAST)	**Employee ID**	**Date of Birth** (MM/DD/YYYY)
Date of Hire (MM/DD/YYYY)		

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

Spouse Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Date Married**
☐ N/A		☐ M ☐ F	

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

BASIC TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Coverage for Employee Only	Benefit Amount	Monthly Premium Amount (Cost per Pay Period – 12/Year)	Elect Coverage	Decline Coverage
Employee	$50,000	Paid by Employer	☒	☐

Additional Information:

SUPPLEMENTAL TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

You must enroll for this coverage in order for your dependents to be eligible for this coverage.

Coverage for Employee Only	Benefit Amount – Select One Option	Monthly Premium Amount (Cost per Pay Period – 12/Year)
Employee (must be in $10,000 increments)	☐ $10,000	$___________
	☐ $20,000	$___________
	☐ $150,000	$___________
	☐ $500,000 (Requires EOI*)	$___________
	☐ $________________	$___________
	☐ Decline Employee Coverage	N/A
Spouse (must be in $5,000 increments)	☐ $5,000	$___________
	☐ $10,000	$___________
	☐ $50,000	$___________
	☐ $250,000 (Requires EOI*)	$___________
	☐ $________________	$___________
	☐ Decline Spouse Coverage	N/A
Child(ren) • The premium amount(s) shown apply to all children, regardless of the number of children you have	☐ $5,000 for each child	$0.23 for all children
	☐ $10,000 for each child	$0.46 for all children
	☐ Decline Child(ren) Coverage	N/A

Additional Information:

- *If you elect an amount that exceeds the guaranteed issue amount of $150,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- *If you elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- The premium amount(s) for you and your spouse are based on your (employee) age; therefore, the premium amount(s) will change as you grow older.
- The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 65.
- The child benefit amount listed applies to any child age 6 months or older. A different amount may apply to any child under the age of 6 months.

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Certain states are community property states. If you live in one of these states – AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or legal advisor for additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the “Important Notice – Fraud Warning Statements” that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE “IMPORTANT NOTICE – FRAUD WARNING STATEMENTS” ON THE FOLLOWING PAGE

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be submit to civil fines and criminal penalties.

For residents of New York (not applicable to Life Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

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

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Enrollment/Change Form

FLEXIBLE SPENDING ACCOUNTS

Employer

Effective Date of Enrollment *(MM/DD/YYYY)*

Employee Name

Hire Date *(MM/DD/YYYY)*

Member ID *(set by employer. Typically an employee ID or SSN.)*

Birth Date *(MM/DD/YYYY)*

Street or PO Box

Email Address

City State ZIP

Phone Number

Employment Status: Full Time Part Time

Please enter your FSA election(s):

Per Pay Deduction Plan Year Election

Medical FSA
Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.

Limited Medical FSA (reimburses dental, vision and/or post-deductible expenses as allowed by your plan)
Note: You cannot elect this account if you elect a Medical FSA. You can elect this account if you are covered under an HSA. In order to accurately track eligible expenses, apply them to the correct deductible threshold and ensure reimbursement of eligible post-deductible expenses, you must indicate the level of coverage you have under your health insurance.

Single Family

Dependent Care FSA

This is a:

New enrollment Change in previous enrollment

If this is a change in enrollment, please check the event that triggered this change:
NOTE: An election can only be changed if the change in status affects eligibility for that coverage. Any change in election must be consistent with the change in status and the change in eligibility

Participant's termination of employment.

Change in employment status of spouse or dependent (including termination or commencement of employment).

Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).

Change in number of tax dependents (including birth, adoption, placement for adoption, death).

Change in work schedule (reduction/increase in hours by employee, spouse or dependent, including a switch between full-time/part-time, a strike/lockout, and commencement of or return from an unpaid leave of absence).

Change in residence or worksite (of employee, spouse, or dependent).

Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).

Change in dependent care cost or provider (for Dependent Care FSA elections only).

Other:

Enrollment/Change Form

FLEXIBLE SPENDING ACCOUNTS

PLEASE CERTIFY THE FOLLOWING:

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may besuspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck onan after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature

Date *(MM/DD/YYYY)*

EMPLOYERS ONLY - This section must be complete for employee to be enrolled

Deduction Cycle: Monthly Semi-monthly Bi-weekly Weekly

Other:

Pay date of first FSA deduction(s):

FSA Pay Dates This Year:

Change in Health Insurance level of Coverage: Single Family

Insurance Coverage Code:

This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.

Return to Scott County Employee Relations.

The Beniversal Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark, and the circles design is a trademark of, Mastercard International Incorporated. The Beniversal card is accepted at qualified merchants accepting Debit Mastercard. The Bancorp Bank; Member FDIC. The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.

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Enrollment/Change Form

Please print and complete all sections.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number:	Employer Name:	Effective Date:
Materials ONLY 1001162 or Exam and Materials 1001163	Scott County	

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ ADD ☐ TERM ☐ CHG	☐ Materials ONLY or ☐ Exam and Materials

Last Name (Employee or subscriber)		First Name	M.I.	Date of Birth
Sex ☐ M ☐ F	Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: ______________________________ Date: ____________________

Short Term Disability Insurance Enrollment/Change Form
Return to: Employee Relations

NATIONAL INSURANCE SERVICES

Enter your information:

Employer Name: **Scott County**					NIS Group Number: **022470**	
Full Name (Last name, First name, Middle Initial):					Date of Hire:	
Home Address:		City:		State:	Zip:	
Social Security Number:	○ Single ○ Married	U.S. Citizen? ○ Yes ○ No*		Date of Birth:		○ Male ○ Female
Occupation/Title:				Hours worked per week:		Base Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

Optional Insurance Benefits:		
○ Elect	○ Decline/Cancel Coverage	* Short-Term Disability Weekly Benefit Amount $____________ You may elect coverage in $100 increments not to exceed 60% of your income or $1,700 (whichever is less).

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

Instructions for the employee: Complete and return this form to your Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.

Short-Term Disability Benefit and Rate Calculation Worksheet

Choose your Short-Term Disability weekly benefit in $100 increments not to exceed 60% of your income (or $1,700, whichever is less).

Instructions:

1. First, figure your maximum weekly benefit based on your salary using calculator #1 below. For example, if you make $45,000 per year, your calculations will look like this: $45,000 x 60% = $27,000 ÷ 52 weeks = $519.23.

2. Next, choose your coverage in $100 increments and figure your cost using calculator #2 below. Be sure you don't exceed $1,700 or your maximum weekly benefit as calculated in #1, whichever is lower. Using the example above with a salary of $45,000, the maximum weekly benefit you can choose is $500. The cost can be figured by dividing $500 by $100, then multiplying by the age rates listed in the chart on the right. For example, if you want $500 of weekly benefit and you are age 47, your calculations will look like this: $500 ÷ $100 = 5 x $4.70 = $23.50 (your monthly premium payment).

1 Calculate Your Maximum Weekly Benefit

$ ___ , ___ Your Annuall Salary

X 60%

= ___ , ___ Subtotal

÷ 52

= $ ___ , ___ . ___ Your maximum Weekly Benefit based on your salary.

Maximum benefit is $1,700 per week. If your weekly benefit amount exceeds $1,700 enter $1,700 here.

2 Calculate Your Monthly Cost

= $ ___ , ___ . ___ **Weekly Benefit** *Enter your coverage amount in $100 increments not to exceed your Maximum Weekly Benefit you calculated above. If your benefit exceeds $1,700, enter $1,700.*

÷ 100

= ___ . ___ Subtotal

X $ ___ . ___ **Your Age Rate** (See Chart)

= $ ___ . ___ **Total Monthly Cost**

Age as of December 1 of the prior year.

Age rates per $100 of weekly benefit.

Age	Rates per $100 of weekly benefit
0-24	$7.20
25-29	$7.60
30-34	$5.60
35-39	$4.20
40-44	$4.00
45-49	$4.50
50-54	$5.60
55-59	$7.00
60-64	$8.60
65 +	$10.50

Administered by:

NATIONAL INSURANCE SERVICES

Corporate Headquarters
250 South Executive Drive, Suite 300, Brookfield, WI 53005
Offices Nationwide
800.627.3660

Underwritten by:

Madison National Life Insurance Company
A Member of The IHC Group

Madison National Life Insurance Company, Inc. is a Wisconsin Insurance company and a Member of the IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for nearly 30 years. For information on the IHC Group, see www.ihcgroup.com.

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