KELLY & ASSOCIATES INSURANCE GROUP, INC.

301 International Circle · Hunt Valley, Maryland 21030-1342 · (410) 527-3432 · Fax: (410) 527-5905 · www.kaig.com

EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters **Please fill in the boxes completely:** ■

☐ New Subscriber ☐ Member adding line of coverage ☐ WAIVER (*Signature Required*) ☐ COBRA or State Continuation

Company Name: **Foundation for Advanced Education in the Sciences** **KELLY Company ID#:** **152734** **Business Phone#:** **(301) 496-8063**

1 EMPLOYEE

Last Name	First Name	MI	Title (Jr., Sr., etc.)

Street Number	Street Name Note: a PO Box address is insufficient for any HSA, FSA, or HRA account	Apt#

City	State	Zip Code	E-mail

Social Security#	Date of Birth (MM-DD-YY)	Gender M ☐ F ☐	Marital Status Single ☐ Married ☐	On your effective date, will you be actively at work on a full-time basis for this employer? Y ☐ N ☐	Hrs/week

Home Phone#	Full-time Hire Date (MM-DD-YY)	Requested Effective Date (MM-DD-YY)	KELLY USE ONLY: E

2 DEPENDENTS

Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Gender	F/T Student (Y/N)**	Disabled (Y/N)	Dependent Elections: Health
	Subscriber						
							☐
							☐
							☐
							☐

*** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)*

If Eligible for Medicare: Effective Date (Part A): / / Effective Date (Part B): / / Effective Date (Part D): / /

3 PLANS

HEALTH PLAN

CareFirst Blue Preferred

Select Level of Coverage:

☐ Individual

☐ Family

☐ Waive Coverage

Award #_____

Institute: (Please check one)

☐ OD	☐ NIDCD	☐ CSR
☐ NCI	☐ NIDCR	☐ FIC
☐ NEI	☐ NIDDK	☐ NCCAM
☐ NHLBI	☐ NIDA	☐ NCMHD
☐ NHGRI	☐ NIEHS	☐ NCRR
☐ NIA	☐ NIGMS	☐ CC
☐ NIAAA	☐ NIMH	
☐ NIAID	☐ NINDS	
☐ NIAMS	☐ NINR	
☐ NIBIB	☐ NLM	
☐ NICHD	☐ CIT	

4 Employee Occupation _____

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name _____

Who is covered? ☐ Self ☐ Spouse ☐ All Policy# _____

Effective Date ____/____/____ Term Date ____/____/____

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that I am the spouse, parent or legal guardian of the dependents listed above. If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. **Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.**

THIS IS NOT AN APPLICATION FOR INSURANCE

6 EMPLOYEE SIGNATURE _____ **DATE** ____/____/____

EMPLOYER SIGNATURE / VERIFICATION _____ **DATE** ____/____/____

KELLY & ASSOCIATES INSURANCE GROUP, INC.
WAIVER OF INSURANCE COVERAGE

Medical/Dental/Vision - Notice of Special Enrollment Period

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage, or if you lose coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or during open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental coverage and you fail to fill out the front of this form concerning your (and/or your eligible dependent's) other coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental coverage.

Non - Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. *Marriage, divorce, or legal separation,*
2. *Birth or adoption of a child,*
3. *Death of a spouse or child,*
4. *Change in residence or work location that affects benefits eligibility for you or your covered dependent(s),*
5. *Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes),*
6. *You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job).*