The Sarasota Ballet

2023-2024 Universal Enrollment/Change Form

Please fill out this form in its entirety. This will assist HR in making sure that the correct payroll deductions are occurring for your chosen benefits. You must sign and date your election form and submit all pages.

Employee Information (highlighted field titles denote required information)

Last Name	First Name	M.I.	Date of Hire (MM/DD/YYYY)

Social Security Number (XXX – XX – XXXX)	Date of Birth (MM/DD/YYYY)	Daytime Phone No. ( )	Gender □ M □ F

Full Home Address (street, city, state, and ZIP code) □ Check box if address has changed from previous year

Worksite/Location Code	E-mail Address	Occupation

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Annual salary $_____ Hours worked per week _____

* **(Salary information is required for salary-based benefit election)**

Reason for election/change(s): □ New Hire □ Open Enrollment □ Qualifying Event (indicate event below) Date of event: _____

Person(s) affected:
□ Self □ Spouse □ Domestic Partner* / Civil Partner* □ Child(ren)
*only where permitted

Qualifying Life Event
□ Adoption □ Birth □ Death □ Marriage □ Divorce
□ Lost other group coverage □ Gained other group coverage

Dependent Information (highlighted field titles denote required information)

Only complete this section if you are covering dependents **□ Check here if you are attaching another page to include additional dependents**

	Last Name, First Name, M.I.	Date of Birth	Social Security Number	Gender	F/T Student? (if over 19 y/o)	Disabled?
□ Spouse:				□ M □ F	□ Y □ N	□ Y □ N
□ Child:				□ M □ F	□ Y □ N	□ Y □ N
□ Child:				□ M □ F	□ Y □ N	□ Y □ N
□ Child:				□ M □ F	□ Y □ N	□ Y □ N

Benefit Election Information

Aetna Medical Plan Coverage (select a plan and a coverage tier)

□ AFA OAAS 5000 80 ER
□ AFA OAAS Essential 1000 50
□ AFA POS 1000 80

□ EE Only
□ EE + Spouse
□ EE + Child(ren)
□ EE + Family

□ **Decline medical coverage [indicate reason below]**
□ Other group coverage □ Tricare □ Medicare
□ Individual coverage □ I have no other coverage
□ Other

_____

Principal Dental PPO (select plan and coverage tier)

□ PPO Low Plan
□ PPO High Plan

□ EE Only
□ EE + Spouse
□ EE + Child(ren)
□ EE + Family

□ Decline dental coverage

Principal Vision VSP (select coverage tier)

□ EE Only
□ EE + Spouse
□ EE + Child(ren)
□ EE + Family

□ Decline vision coverage

Principal Voluntary Life/AD&D

□ Employee Life Benefit Amount $_____

□ Spouse Life Benefit Amount $_____

□ Child Life Benefit Amount $_____

□ **Decline Voluntary Life/AD&D**

Principal Short Term Disability

□ **Elect Short Term Disability**

□ Decline Short Term Disability

60% of your earnings up to $1,000 weekly. See Benefit Guide for Rate Calculation.

PRIMARY BENEFICIARY(IES)

Full Name and Full Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

CONTINGENT BENEFICIARY(IES)

Full Name and Full Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all contingent beneficiaries.

- ✓ This beneficiary designation revokes all revocable prior beneficiary designations.
- ✓ Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- ✓ If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Authorization and acknowledgement of special enrollment rights:

I hereby authorize any health plan, provider of healthcare services or their Business Associates who have any records, knowledge, or Protected Health information of me or any family member for whom coverage is requested, to share information with the insurance carriers who provide services for the plans described herein, for the purposes of determining eligibility for enrollment or underwriting for me and for my family members. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage.

Providing this authorization makes it possible to determine your eligibility for enrollment in these plans. I hereby elect the benefit choices indicated above and direct and authorize HIVE LLC to deduct from my wages the amount of my cost of the coverages designated. This authorization and the benefit choices above shall continue in effect until the next open enrollment unless a qualifying change in employment or family status occurs. I further understand that by electing coverage under this plan, I am authorizing HIVE LLC to deduct my contributions for medical, dental, and vision before taxes are withheld.

Note: Any person who knowingly and with intent to injure, defraud or deceive and the insured files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony and may result in the denial of claims or cancellation of coverage. In addition, I may be subject to civil and/or criminal penalties as well as termination from my employment.

SPECIAL ENROLLMENT RIGHTS:

~ If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
~ If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
~ If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
~ I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understood the benefit summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.
~ I understand and agree that I must satisfy all active work, active employment and/or active eligibility requirements that pertain to the policy to be eligible for coverage.

Employee Signature: _____ Date: _____