Driver 2016 New Hire

Complete and Return no later than 12/14/2015

Please use black ink and be sure to sign at the bottom

The rates below are Monthly Rates

Employee portion of health is offset by Health & Welfare funds.

Employee Name: ______________________ Date of Birth ______________

Gender________ SSN ______________

Address ______________ City ______________ State ________ ZIP ________

Dependents

Marital Status (Circle One) Single / Legally Married / Domestic Partner

Spouse ____________	Date of Birth ____________	Gender ______	SSN ____________
Child ____________	Date of Birth ____________	Gender ______	SSN ____________
Child ____________	Date of Birth ____________	Gender ______	SSN ____________
Child ____________	Date of Birth ____________	Gender ______	SSN ____________

HEALTH INSURANCE: ◯ Declining Health Coverage (complete back of form)

HSA $1,500/$3,000 100% (Option 1) ◯ **$640.18 Employee Only** ◯ **$1281.56 Empl+Spouse** ◯ **$990.02 Empl+1 Child** ◯ **$1339.88 Empl+Children** ◯ **$1981.28 Family**

HSA $3,500/$7,000 100% (Option 2) ◯ **$545.08 Employee Only** ◯ **$1081.88 Empl+Spouse** ◯ **$837.88 Empl+1 Child** ◯ **$1130.68 Empl+Children** ◯ **$1667.48 Family**

HSA DEPOSITS

Please withhold $________ annually or $_______ per pay period from my check and deposit tax-free into my HSA Account

DENTAL INSURANCE: ◯ Declining Dental Insurance Coverage

Dental ◯ **$25.81 Empl Only** ◯ **$50.44 Empl+Spouse** ◯ **$68.14 Empl+Child(ren)** ◯ **$93.80 Family**

VISION INSURANCE: ◯ Declining Vision Insurance Coverage

Vision ◯ **$7.66 Empl Only** ◯ **$12.26 Empl+Spouse** ◯ **$12.51 Empl+Child(ren)** ◯ **$20.17 Family**

VOLUNTARY SHORT TERM DISABILITY ◯ Elect ◯ Declining Short Term Disability Insurance Coverage

VOLUNTARY LONG TERM DISABILITY: ◯ Elect ◯ Declining Long Term Disability Insurance Coverage

VOLUNTARY TERM LIFE INSURANCE ◯ Declining Voluntary Term Life Insurance Coverage

- The employee must elect coverage in order for the spouse and child(ren) to be covered
- Maximum coverage for the spouse is 50% of Employee coverage (up to $150,000 spouse in $25,000 increments) and for children 10% of the employee amount to $20,000 children in $2,500 increments)

Employee $25,000 ◯ **ELECT**	**Employee** $50,000 ◯ **ELECT**	**Employee** $100,000 ◯ **ELECT**	**Employee** $150,000 ◯ **ELECT**	**Employee** $175,000 ◯ **ELECT**	**Employee** $200,000 ◯ **ELECT**	**Employee** $250,000 ◯ **ELECT**	**Employee** $300,000 ◯ **ELECT**
Spouse $12,500 ◯ **ELECT**	**Spouse** $25,000 ◯ **ELECT**	**Spouse** $50,000 ◯ **ELECT**	**Spouse** $75,000 ◯ **ELECT**		**Spouse** $100,000 ◯ **ELECT**	**Spouse** $125,000 ◯ **ELECT**	**Spouse** $150,000 ◯ **ELECT**
Child(ren) $2,500 ◯ **ELECT**	**Child(ren)** $5,000 ◯ **ELECT**	**Child(ren)** $10,000 ◯ **ELECT**	**Child(ren)** $15,000 ◯ **ELECT**		**Child(ren)** $20,000 ◯ **ELECT**		

MEDICAL HISTORY (*only required if you elect coverage ABOVE the employee Guarantee Issue amount ($200,000), spouse/child amount over need included Evidence of Insurability Form.)

Complete the following question if you are enrolling for employee Voluntary Life and electing an amount above the Guarantee Issue Amount:

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to AIDS or AIDS Related Complex; or any other Chronic Condition?

◯ Yes, I have______________________ ◯ No

An Evidence of Insurability form must be completed if you answer "Yes" to the question above and Spouse and Children wanting above the Guaranteed Issue limits.

Beneficiary Election

Employee Life: Primary Beneficiary Election: ______________ Relation to you: ________

Employee Life: Contingent Beneficiary Election: ______________ Relation to you: ________

Spouse Life: Primary Beneficiary Election: ______________ Relation to you: ________

Child(ren) Life: Primary Beneficiary Election: ______________ Relation to you: ________

Ask for a beneficiary form for more detailed beneficiary arrangements or if your spouse is not your primary beneficiary choice.

I authorized the company to take the eligible premiums from my check and as much pre-tax as possible. If I answered the health question I certify it is correct.

SIGNATURE: ______________________

PRINT NAME:______________________ **EMPL. #:** ____________ **DATE:**_________

NOTE: If you are declining Health Insurance Coverage -- please complete back of form.

Waiver of Insurance Coverage
Plan Year 2016

You may only opt out of the Hoovestol Health Plan if you have qualified coverage elsewhere. If you have verifiable coverage under a spouse's, parent's group coverage, VA, Medicare or other qualified plans, a waiver will be granted.

A waiver is granted only when the employee completes this waiver form and submits it along with proof of qualifying health care coverage to the Benefits Department.

Indicate the type of qualifying coverage you have: ______________________________

Company or Government Agency sponsoring coverage: ___________________________

Insurance company name: ____

Policy Number: ____

For COBRA indicate your coverage end date: ________________________

Additional information or proof of coverage may be required.

Employee Signature: _________________________________

Employee Print Name: _______________________________

Employee Number: _______________________ Date: ___________________

Internal Use Only:

Copy of card attached:

Yes: _____ No: _____ Date Received: _______________________