44NORTH
ACRISURE® PARTNER

EDUCATION MANAGEMENT & NETWORK, INC
BENEFIT ELECTION & CHANGE FORM

Email: enrollment@44N.com or fax: 855-306-1098

*Please **print CLEARLY** and complete **ALL** fields*

ENROLLMENT TYPE: ☒ **Open Enrollment** ☐ **New Hire** ☐ **Change**

EMPLOYEE INFORMATION

Reason for Change: ☐ Loss of Coverage ☐ Birth ☐ Adoption/Legal Guardian ☐ Marriage ☐ Name Change/Address

NAME:		EFFECTIVE DATE: **11/01/2023**		
SSN:	DATE OF BIRTH:	DATE OF HIRE:	☐ M ☐ F	☐ Married ☐ Single
MAILING ADDRESS:		CITY:	ST:	ZIP:
LOCATION: ☐CANIFF ☐NEW DAWN ☐OAKLAND		ANNUAL SALARY:	PHONE:	

MEDICAL COVERAGE	VISION COVERAGE	DENTAL COVERAGE	DISABILITY
HAP HMO ☐ Yes, I would like to enroll – MUST COMPLETE PCP FORM if your first time enrolling ☐ WAIVE – MUST COMPLETE A WAIVER FORM	**VSP VISION** ☐ YES, I would like to enroll ☐ NO, Waive Coverage	**DELTA DENTAL** ☐ YES, I would like to enroll ☐ NO, Waive Coverage	**LINCOLN** ☒ STD

COVERAGE	DEPENDENT NAME (FIRST MI LAST)	SSN	DATE OF BIRTH	RELATIONSHIP	SEX
☐ Medical ☐ Vision ☐ Dental	(1)				☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental	(2)				☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental	(3)				☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental	(4)				☐ M ☐ F
☐ Medical ☐ Vision ☐ Dental	(5)				☐ M ☐ F

Please select a Primary Care Physician (PCP)

Name of Member	Member's Provider Name & Address

COORDINATION OF BENEFITS INFORMATION – PLEASE COMPLETE IF YOU, YOUR SPOUSE, OR DEPENDENT(S) HAVE ANY OTHER COVERAGE

OTHER COVERAGE ☐ YES ☐ NO If Yes, Complete Below

	Member Name(s)	Other Carrier Name	Group Number	Employer Name
☐ MEDICAL/PRESCRIPTION				
☐ DENTAL				
☐ VISION				

MEDICARE ENROLLEES *	☐ YOURSELF	MEDICARE #:	☐ Age ☐ Disability ☐ ESRD
MEDICARE ENROLLEES *	☐ SPOUSE	MEDICARE #:	☐ Age ☐ Disability ☐ ESRD
MEDICARE / MEDICAID / OTHER*	☐ ELIGIBLE DEPENDENT	DEPENDENT NAME(S):	ID # ☐ ESRD

** If you, your spouse or any dependent(s) listed are enrolled in Medicare, please attach a copy of your Medicare card(s)*

☒ YES, I ELECT TO PARTICIPATE IN QUALIFIED PRE-TAX PREMIUMS (Contact the HR Department for after tax options)

CERTIFICATION- You must sign this form to complete your enrollment.
By signing this form, I certify that these are my benefit elections and that:

1. I understand that having agreed to enroll, that I will have no right to participate in the benefit plans and that these benefits will not be available to me, until I have completed, signed and returned the enrollment form and my enrollment is accepted. I understand that as of the first day of the plan year, which this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in my family status as defined in the Plan Documents. I understand that coverage applies only to expenses incurred during my participation in the plan.
2. I authorize the "pre-tax" deduction of a portion of my salary based on the benefit coverage's I have elected above to be deposited in equal deposits as my personal Benefit Credits until I revoke or replace such and I understand that my share of the cost of the benefits under the group health insurance plan may be adjusted from time to time to reflect the change in rates charged by the carriers. I understand that my unused contributions made under this plan cannot be refunded to me and become the property of my employer.
3. I understand that pre-tax contributions paid under this Salary Reduction Agreement reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation which is considered for Social Security Purposes

Employee Signature: _____ Date: _____