SCHWARTZ BROTHERS RESTAURANTS
2021-22 EMPLOYEE ENROLLMENT / WAIVER FORM

HMA Group #: 020203
VSP Group #: 30024563

A. Employee Information

Employee Last Name _____ **First Name** _____ **M.I.** _____

Social Sec # _____ **Date of Birth** _____ **Sex** ☐ M ☐ F **Phone** (_____)_____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

B. Benefit Selection and Bi-Weekly Contribution

☐ **I am currently enrolled in the Plan and do not want to make any changes at this time.** I understand that the payroll deductions listed below will become effective March 1st, and my current plan/dependent elections will continue for the 2021-2022 plan year. Please check this box and proceed to section G. (This option does not apply to new hires.) *(Note: If you do not make any changes during the open enrollment period, you must wait until next open enrollment.)*

☐ Waiving Coverage – Reason for Waiving:

- ☐ *I am covered by my spouse's medical plan*
- ☐ *I am covered by my parent's medical plan*
- ☐ *I am covered by Medicare (generally for people aged 65 & older)*
- ☐ *I am covered by Medicaid (called "Apple Health" in Washington)*
- ☐ *I have other medical coverage not listed above*
- ☐ *Other:*_____

☐ New Enrollee (Please make benefit selections below.)

☐ Coverage Change ☐ Name Change ☐ Address Change

☐ Drop Spouse/Dependent Reason: _____ Effective date of change: _____

☐ Add Spouse/Dependent* Reason: _____ Effective date of change: _____

If Adding Spouse - Date of Marriage: _____

*(*If adding dependent(s) due to adoption, court order, or legal guardianship, you must provide legal documentation.)*

2021 – 2022 Payroll Deductions (Bi-Weekly)	**Medical Only** *(HMA)*	**Dental** *(HMA)* Must elect medical to elect dental	**Vision** *(VSP)* Must elect medical to elect vision	**TOTAL** Add checked items in each row to calculate total bi-weekly contributions.
Employee Only	☐ $76.62	☐ $15.69	☐ $3.54	
Employee, Spouse Only	☐ $221.54	☐ $31.85	☐ $5.67	
Employee, Child(ren) Only	☐ $197.08	☐ $33.69	☐ $5.78	
Employee, Spouse and Child(ren)	☐ $330.92	☐ $54.46	☐ $9.33	

C. Enrollment Information

Coverage Elections: ☐ Myself ☐ Spouse ☐ Child(ren)

List below all dependents (Spouse/Children) you wish to cover: (sex, date of birth, and social security number required)

First Name	M.I.	Last Name	Sex	Date of Birth	Relationship D=Daughter S=Son	Social Security # (Required Field)
					Spouse	

If dropping spouse/dependents please list name(s):

Name: _____ Term date: _____ Reason: _____

Name: _____ Term date: _____ Reason: _____

D. Disabled Child Eligibility

List dependent who is developmentally disabled or physically handicapped who is over age 25:

Name: _____ Medical documentation must be submitted within 31 days of the effective date of coverage.

E. Coordination of Benefits Information

Currently do you, your spouse or any of your children have coverage through another insurance plan? ☐ Yes ☐ No

If yes, please complete the following:

Marital Status: ☐ Single ☐ Married_____ ☐ Widowed ☐ Legally Separated ☐ Divorced
Name of Spouse

If divorced, is there a court order for provision of the child? ☐ Yes ☐ No If yes, please attach a copy of the court decree. Per court decree:

Who has custody of child? _____ Who provides insurance for child? _____

Please list the full name of the child(ren):

_____

_____

Your elections cannot be processed without your signatures!

Turn over for required signature

Please list both the natural parents name and date of birth:

Natural Father _____ / DOB _____ Natural Mother _____ / DOB _____

✶ List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage:	Carrier Name:
_____	_____	_____	__/__/____	_____
_____	_____	_____	__/__/____	_____
_____	_____	_____	__/__/____	_____
_____	_____	_____	__/__/____	_____

Provide the following information on the carriers listed above:

Carrier Name: _____ Policy Number: _____

Street Address: _____ City: _____ State _____ Zip _____

Carrier phone #: _____

Subscriber's Name: _____ Social Security Number: _____ Date of birth: _____

Employer's Name and Address (if group coverage) _____

Is Employee, Spouse covered under this medical plan eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility for Medicare Part A _____ Date of eligibility for Medicare Part B _____

Social Security No._____

F. Life Insurance Beneficiary

Beneficiar(ies)	Name & Address	Relationship	Social Security Number	Date of Birth	Phone Number	Benefit %
Primary						
Primary						
Primary beneficar(ies) are first in line to inherit your life insurance. You can name one sole primary beneficiary or name more than one primary beneficiary and divide the benefit amount between them. ***Be sure to indicate benefit percentages – total must equal 100%***						
Contingent						
Contingent						
Contingent Beneficiar(ies) inherit the life insurance if the primary beneficiar(ies) are not living or cannot be located at the time of your death. You can name one sole contingent beneficiary or name more than one contingent beneficiary and divide the benefit amount between them. ***Be sure to indicate benefit % - the total must equal 100%.*** **Important: If you have more than two primary or contingent beneficiaries to list, please ask Human Resources for a Unum beneficiary form to ensure beneficiaries are clearly documented.**						

G. Employee Release & Authorization **If submitting electronically check the "I agree" box below, otherwise sign on the signature line**

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. *By signing this form, I attest that all dependent children listed for coverage are under age 26.* I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent.

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. *

Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.
* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available upon request.

I agree to continue enrollment in the health plan during the plan year unless I have a special qualifying event or until the next open enrollment period.

If completing and submitting enrollment form electronically (via email) please check the "I agree" box and email form to paylocity@schwartzbros.com

☐ **I agree**. *By checking the "I Agree" checkbox, I agree and it is my intent to electronically sign and electronically submit this Authorization/Enrollment Form. I understand that by checking the "I agree" checkbox, I will be applying my electronic signature to this Authorization/Enrollment Form and that I will be bound with the same*

Employee's Signature_____ **Date Signed** ____/____/____

☐ I request hardcopies of the enrollment materials. Please mail an enrollment kit to my home address.

H. EMPLOYER SECTION

Date Hired: ____/____/____ Coverage Effective Date: ____/____/____ Special Enrollment: ☐ Y ☐ N Late Enrollment: ☐ Y ☐ N

Certified by: _____ Today's Date: ____/____/____ Location: _____ Average Hours: _____