Benefit Election Form
Plan Year 01/01/2021 – 12/31/2021

A. EMPLOYEE INFORMATION			
Employee Name:			SSN:
Home Address: (if **new address**, please check this box ❑)	City:	State:	Zip Code:
Date of Birth: / Date of Hire:	Phone #:	Gender (circle): MALE FEMALE	
Email:			

❑ Open Enrollment ❑ New Hire ❑ Reinstatement ❑ Maintain Current Coverage & Enrollment ❑ Other

Dependent Name: (Spouse)	Date of Birth:	Gender:	Social Security #:
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Dependent Name:	Date of Birth:	Gender:	Social Security #:

B. Benefit Election	**M&M Home Care will contribute up to $150.00 per month toward the premium for those employees enrolling in the group medical coverage with Total Health Care. The below employee contribution shown has the $150.00 taken out of the monthly premium**
	Total Health Care – Basic HMO $1,000/0% Plan
❑ Employee	❑ $221.07
❑ Employee + 1	❑ $592.14
❑ Family	❑ $1,000.32

❑ **I decline Medical coverage because I have qualified coverage elsewhere.** I understand that I cannot change my election until the next open enrollment unless I have an eligible change in status.

C. Voluntary Dental	**Principal PPO Plan – Monthly Deduction**
❑ Employee	❑ $32.03
❑ Employee + Spouse	❑ $64.07
❑ Employee + Child(ren)	❑ $79.25
❑ Employee + Family	❑ $122.34

❑ **I decline Voluntary Dental coverage because I have qualified coverage elsewhere.** I understand that I cannot change my election until the next open enrollment unless I have an eligible change in status.

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D. Voluntary Vision	VSP PPO Plan – Monthly Deduction
❑ Employee	❑ $6.56
❑ Employee + Spouse	❑ $13.11
❑ Employee + Child(ren)	❑ $14.03
❑ Employee + Family	❑ $22.41

❑ **I decline Voluntary Vision coverage because I have qualified coverage elsewhere.** I understand that I cannot change my election until the next open enrollment unless I have an eligible change in status.

E. Authorization

I understand that:

My regular pay will be reduced by the amount of my required contribution for the benefit options I have elected above and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option selected is set forth in the Annual Enrollment materials that have been provided to me.

I cannot change or revoke this benefit election or compensation reduction agreement to be effective as of any date prior to the next January 1, unless that change or revocation is on account of and consistent with an eligible change in status or other such events as the plan administrator determines will permit a change or revocation of anelection.

Prior to January 1 of each year, I will be offered the opportunity to change my benefit elections for the following plan year (January 1 – December 31). If I do not complete and return a new M&M Home Care Benefit Election Form at that time, I will be treated as having **not** elected to continue for the new plan year those benefits which are available to me.

My signature below, acknowledges all choices on this enrollment form.

Employee Signature:	**Date:**

All carrier forms (Enrollment or Waiver) and this Election Form need to be returned to M&M Home Care. This includes those electing coverage or waiving coverage. Eligible **newly hired** employees who do not return the forms back will be considered as having waived coverage and will not have another opportunity to enroll until the next Open Enrollment period.

Who Do You BENEFIT With?

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