ELECTION FORM 2023-2024

CLIENT NAME: Pyramid Lake Paiute Tribe					
EMPLOYEE NAME:			EFFECTIVE DATE:		
I authorize the applicable payroll deductions for my coverage selections below. Please check one box only per section.					
Medical – PPO Plan	□ EE Only	□ EE + Spouse	□ EE + Child(ren)	□ EE +Family	□ Waive
Dental	□ EE Only	□ EE + Spouse	□ EE + Child(ren)	□ EE +Family	□ Waive
Vision	□ EE Only	□ EE + Spouse	□ EE + Child(ren)	□ EE +Family	□ Waive
Life/AD&D	X EE Only				

Per Paycheck Rates

Effective: 02/01/2023

Medical: PPO	
Hometown Health	
Employee Only	$0.00
Employee + Spouse	$574.74
Employee + Child(ren)	$383.18
Family	$1,005.81

Life	
Anthem	
Employee Only	$0.00

Vision	
Anthem	
Employee Only	$2.94
Employee + Spouse	$5.00
Employee + Child(ren)	$5.29
Family	$7.99

Dental	
Anthem	
Employee Only	$17.97
Employee + Spouse	$35.96
Employee + Child(ren)	$43.37
Family	$66.07

I acknowledge I have been given the opportunity to apply for this medical coverage, and I have been provided all of the open enrollment materials necessary to make this decision. I understand that my election cannot be changed or canceled unless I experience an IRS qualified change in family status. I also understand that if I choose to waive enrollment at this time, I will be unable to enroll until next open enrollment unless I experience a qualified loss in current coverage. Changes must be submitted to Human Resources within 30 days of the qualifying event date, or the change cannot be processed until the next open enrollment period.

I acknowledge that I have received all applicable Annual Compliance Notices for this plan year and all items distributed are in *accordance with current ERISA, HIPAA, Medicare, PPACA, and Department of Labor regulations*.

SIGNATURE:	**DATE:**

BENEFITS ENROLLMENT FORM

Personal Data

Employee Name (First, Middle Initial, Last)		Social Security Number		Date of Birth (MM/DD/YYYY)
Home Address	**City**		**State**	**Zip Code**
Home Phone Number	**Gender**	**Marital Status** ☐Single ☐Married ☐Divorced ☐Widowed	**Date of Marriage**(MM/DD/YYYY) *(complete if adding spouse)*	**Date of Hire**
Occupation	**Location**		**Salary (HR use only)**	

Dependent Data (REQUIRED IF ENROLLING SPOUSE OR CHILDREN IN ANY BENEFITS)

	Name: First, Middle Initial, Last	Date of Birth	Gender	SSN	Check Coverage
Add ☐ Remove ☐	Spouse/Partner				☐ Medical ☐ Dental ☐ Vision
Add ☐ Remove ☐	Child				☐ Medical ☐ Dental ☐ Vision
Add ☐ Remove ☐	Child				☐ Medical ☐ Dental ☐ Vision
Add ☐ Remove ☐	Child				☐ Medical ☐ Dental ☐ Vision
Add ☐ Remove ☐	Child				☐ Medical ☐ Dental ☐ Vision
Add ☐ Remove ☐	Child				☐ Medical ☐ Dental ☐ Vision
Add ☐ Remove ☐	Child				☐ Medical ☐ Dental ☐ Vision

Beneficiary Information

PRIMARY BENEFICIARY 1 Full Name	Full Address	Relationship	Date of Birth	Social Security Number	Percentage
PRIMARY BENEFICIARY 2 Full Name	**Full Address**	**Relationship**	**Date of Birth**	**Social Security Number**	**Percentage**

Total: 100%

CONTINGENT BENEFICIARY Full Name	Full Address	Relationship	Date of Birth	Social Security Number	Percentage of Benefit

Note: A contingent beneficiary will receive benefits only if the primary beneficiary does not survive you. If you wish to designate more than one primary or contingent beneficiary, please attach a separate sheet of paper. Primary beneficiary percentages must total 100%.