Caring Home Health

MultiPlan/PHCS Third Party Medical Plan

Effective 10/01/2018

Payroll Deduction Form

Employee Name:_____ Date of Birth:_____

Social Security #:_____ Gender (M/F)_____ Phone#:_____

Mailing Address:_____

Email Address:_____ Avg. Hours Worked/Week:_____

Dependent Information:

Last Name	First Name	MI	Social Security #	Date of Birth	Gender (M/F)	Relationship to Employee

Please initial next to the plan option you are selecting for this Health Insurance Plan Year:

Plan Bronze 402 MVP	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$553.30	$438.30	$115.00	$57.50	_____
Employee+Spouse	$968.06	$438.30	$529.76	$264.88	_____
Employee+Child(ren)	$737.18	$438.30	$298.88	$149.44	_____
Employee+Family	$1,151.95	$438.30	$713.65	$356.83	_____

Plan Bronze 401	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$573.44	$438.30	$135.14	$67.57	_____
Employee+Spouse	$1009.16	$438.30	$570.86	$285.43	_____
Employee+Child(ren)	$766.61	$438.30	$328.31	$164.16	_____
Employee+Family	$1,202.33	$438.30	$764.03	$382.02	_____

Plan Bronze 400	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$601.64	$438.30	$163.34	$81.67	_____
Employee+Spouse	$1,066.69	$438.30	$628.39	$314.20	_____
Employee+Child(ren)	$807.81	$438.30	$369.51	$184.76	_____
Employee+Family	$1,272.85	$438.30	$834.55	$417.28	_____

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Caring Home Health

Plan DENTAL PPO	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$37.08	$0	$37.08	$18.54	_____
Employee+Spouse	$71.69	$0	$71.69	$35.85	_____
Employee+Child(ren)	$92.63	$0	$92.63	$46.32	_____
Employee+Family	$127.25	$0	$127.25	$63.63	_____

Plan DENTAL HMO	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$13.74	$0	$13.74	$6.87	_____
Employee+Spouse	$22.93	$0	$22.93	$11.47	_____
Employee+Child(ren)	$30.47	$0	$30.47	$15.24	_____
Employee+Family	$40.75	$0	$40.75	$20.38	_____

Plan VISION	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Employee Only	$8.79	$0	$8.79	$4.40	_____
Employee+Spouse	$17.58	$0	$17.58	$8.79	_____
Employee+Child(ren)	$19.34	$0	$19.34	$9.67	_____
Employee+Family	$28.12	$0	$28.12	$14.06	_____

Plan Life & AD&D	Monthly Premium	Employer Contribution	Employee Cost	Per Pay Period Cost	Initial Below to Elect Coverage
Coverage Amount	_____	_____	_____	_____	_____
Primary Beneficiary	% _____	_____	_____	_____Relationship	_____
Contingent	%_____	_____	_____	_____Relationship	_____
_____	_____				

Declination of Coverage: I hereby waive coverage for (Check All That Apply**)**

Medical	Myself ☐	My Spouse ☐	My dependent	children ☐	
Dental	Myself ☐	My Spouse ☐	My dependent	children ☐	
Vision	Myself ☐	My Spouse ☐	My dependent	children ☐	
I decline to apply for group coverage because of: Spousal Coverage ☐		*Medicare*		*Supplement* ☐	*Individual Coverage* ☐

Other Coverage ☐

By signing below I understand that the employee cost of the above elections will be deducted from each paycheck starting the month that coverage will be effective. I acknowledge that the coverage available to me has been explained to me and I knowingly have elected to enroll in this coverage. I understand, agree and represent that I have read this document or it has been read to me and that the answers provided within this entire document are to the best of my knowledge and belief, and are true and complete. I understand that if any intentional material false statement, misrepresentation or omission is contained here my coverage could be reduced, denied or voided. I further authorize my employer to deduct from my earnings the contributions (if any) elected above I acknowledge that at any time I may be required to complete additional applications at the request of the insurance carrier.

_____ _____

Employee Signature **Date**