

Caring Home Health

Humana NPOS 16 Canopy OPT 38/Reg RX

Effective 10/01/2021

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:

| NPOS 16 Canopy | Monthly Premium | Employer Contribution | Employee Cost | Per Pay Period Cost | Initial Below to Elect Coverage |
|---------------------|-----------------|-----------------------|---------------|---------------------|---------------------------------|
| Employee Only | \$637.46 | \$523.86 | \$114.00 | \$57.00 | _____ |
| Employee+Spouse | \$1403.29 | \$523.86 | 879.43 | \$439.72 | _____ |
| Employee+Child(ren) | \$1211.94 | \$523.86 | \$688.08 | \$344.04 | _____ |
| Employee+Family | \$2041.15 | \$523.86 | \$1517.29 | \$758.65 | _____ |

| Plan DENTAL PPO | Monthly Premium | Employer Contribution | Employee Cost | Per Pay Period Cost | Initial Below to Elect Coverage |
|---------------------|-----------------|-----------------------|---------------|---------------------|---------------------------------|
| Employee Only | \$37.97 | \$0 | \$37.97 | \$18.99 4 | _____ |
| 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 | _____ |

OVER- 

Caring Home Health

| Plan VISION | Monthly Premium | Employer Contribution | Employee Cost | Per Pay Period Cost | Initial Below to Elect Coverage |
|---------------------|-----------------|-----------------------|---------------|---------------------|---------------------------------|
| Employee Only | \$9.82 | \$0 | \$9.82 | \$4.71 | _____ |
| Employee+Spouse | \$19.62 | \$0 | \$19.62 | \$9.81 | _____ |
| Employee+Child(ren) | \$21.58 | \$0 | \$21.58 | \$10.79 | _____ |
| Employee+Family | \$31.38 | \$0 | \$31.38 | \$15.69 | _____ |

| 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 <input type="checkbox"/> | My Spouse <input type="checkbox"/> | My dependent children <input type="checkbox"/> | |
| Dental | Myself <input type="checkbox"/> | My Spouse <input type="checkbox"/> | My dependent children <input type="checkbox"/> | |
| Vision | Myself <input type="checkbox"/> | My Spouse <input type="checkbox"/> | My dependent children <input type="checkbox"/> | |
| I decline to apply for group coverage because of: Spousal Coverage <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Individual Coverage <input type="checkbox"/> | | | | |

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

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION

| | |
|-----------------------|--------------------------------|
| Employee Name: | Effective Date: |
| Address: | City / State / Zip: |
| Birth Date: | Social Security Number: |
| Phone: | Email: |

CHOOSE YOUR METHOD OF DIRECT DEPOSIT:

I request my payroll deduction / direct deposit be placed in the following account(s):


| BANK / CREDIT UNION | BANK ABA# | ACCOUNT# | DEDUCTION AMOUNT / NET PAY | TYPE OF ACCOUNT |
|---------------------|-----------|----------|---|---|
| | # | # | <input type="checkbox"/> \$ _____ or <input type="checkbox"/> _____% | <input type="checkbox"/> Savings <input type="checkbox"/> Checking |
| | # | # | <input type="checkbox"/> \$ _____ or <input type="checkbox"/> _____% | <input type="checkbox"/> Savings <input type="checkbox"/> Checking |

PLEASE PROVIDE A VOIDED CHECK FOR EACH CHECKING ACCOUNT LISTED ABOVE.

AND / OR:

rapid! PayCard Issuance Authorization Form

| | |
|---|--|
| Financial Institution Name: MetaBank® Routing Number: 124085244 Direct Deposit Account Number: 353 _____ <small>(Card ID on front of envelope)</small> <i>To be assigned and entered by CARING HOME HEALTH</i> | DEDUCTION AMOUNT / NET PAY <input type="checkbox"/> \$ _____ or <input type="checkbox"/> _____% |
|---|--|



The rapid! PayCard® Mastercard Card is issued by MetaBank®, Member FDIC, pursuant to a license by Mastercard International Incorporated. Prepaid card can be used wherever Debit Mastercard is accepted. Mastercard is a registered trademark of Mastercard International Incorporated.

Important Information for opening a Card account: To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires all financial institutions and their third parties to obtain, verify, and record information that identifies each person who opens a Card account. What this means for you: When you open a Card account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I authorize CARING HOME HEALTH to withhold the indicated amount(s), if available, from my pay, and deposit directly into the account(s) shown and/or I hereby authorize CARING HOME HEALTH to assign a rapid! PayCard and initiate credit entries and any correcting entries to my assigned rapid! PayCard account. The direct deposit(s) will be made on each payday, unless I notify CARING HOME HEALTH in writing of my intent to cancel. Upon CARING HOME HEALTH's receipt of a request to cancel a direct deposit authorization, it shall become effective after a reasonable opportunity to act upon it.

In the event funds are deposited erroneously into my account, I authorize CARING HOME HEALTH to debit my account(s) not to exceed the original amount of the credit.

I understand that CARING HOME HEALTH reserves the right to refuse any direct deposit request. I also understand that all direct deposits are made through the Automated Clearing House (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Note: If sending this form electronically, please type your initials and the last 4 digits of your social security number in the signature field. If sending or faxing a paper copy, please print out and sign your name(s) in the signature box.

Employee Signature: _____ Date: _____

FORMATO DE AUTORIZACIÓN PARA DEPÓSITO DIRECTO

| | |
|-----------------------------|-------------------------------------|
| Nombre del Empleado: | Fecha: |
| Dirección: | Ciudad/Estado/Código Postal: |
| Fecha de Nacimiento: | Número de Seguro Social: |
| Teléfono: | Correo Electrónico: |

ELIJA EL MÉTODO DE DEPÓSITO DIRECTO:

Solicito que la deducción de mi pago/depósito directo sea puesto en la(s) siguiente(s) cuenta(s):

| BANCO / CREDIT UNION | No. ABA DEL BANCO | No. DE CUENTA | MONTO A DEDUCIR / PAGO NETO | TIPO DE CUENTA |
|----------------------|-------------------|---------------|--|---|
| | # | # | <input type="checkbox"/> \$ _____ o <input type="checkbox"/> _____% | <input type="checkbox"/> Ahorros <input type="checkbox"/> De Cheques |
| | # | # | <input type="checkbox"/> \$ _____ o <input type="checkbox"/> _____% | <input type="checkbox"/> Ahorros <input type="checkbox"/> De Cheques |

FAVOR DE ENTREGAR UN CHEQUE ANULADO POR CADA CUENTA INDICADA EN LA PARTE SUPERIOR.

Y / O:

Formato de Autorización para la emisión de la rapid! PayCard

| | |
|---|---|
| Nombre de Institución Financiera: MetaBank® | MONTO A DEDUCIR / PAGO NETO <input type="checkbox"/> \$ _____ o <input type="checkbox"/> _____% |
| Número de Ruta del Banco: 124085244 | |
| Número de Cuenta: 353 _____ (Número de Card ID al frente del sobre) | |

Asignado e ingresado por CARING HOME HEALTH



La Tarjeta rapid! PayCard® Mastercard es emitida por MetaBank®, Miembro FDIC, conforme a una licencia de Mastercard International Incorporated. La tarjeta prepagada puede ser utilizada dondequiera que se acepten las tarjetas de Débito Mastercard. Mastercard es una marca registrada de Mastercard International Incorporated.

Información importante para la apertura de una cuenta de Tarjeta: Para ayudar al gobierno federal a combatir el financiamiento del terrorismo y las actividades de lavado de dinero, la Ley Patriota de EE.UU. (USA PATRIOT ACT) requiere que todas las instituciones financieras y terceras partes soliciten, verifiquen y registren la información que identifica a cada persona que abre una cuenta de Tarjeta. ¿Qué significa esto para usted?: Cuando usted abre una Cuenta de Tarjeta, se le pedirá su nombre, dirección, fecha de nacimiento y otra información que nos permita identificarlo. También podemos pedir ver su licencia de conducir u otros documentos de identificación.

Controles del Idioma Inglés: La información anterior ha sido traducida al español sólo para su conveniencia. La traducción puede no representar con exactitud el significado de términos, condiciones y descripciones presentadas en el idioma Inglés. El idioma Inglés controla el significado del contenido de esta información.

Autorizo a CARING HOME HEALTH a retener la cantidad indicada(s), de ser disponible, de mi sueldo, y depositar directamente a la cuenta(s) que se muestra y/o por medio de la presente autorizo a CARING HOME HEALTH asignarme una rapid! PayCard e iniciar entradas de crédito y cualquier entrada de corrección a mi cuenta asignada de rapid! PayCard. El depósito directo(s) se realizará en cada día de pago, a menos que notifique a CARING HOME HEALTH por escrito mi intención de cancelar la cuenta. Una vez que CARING HOME HEALTH reciba una solicitud de cancelación a la autorización de depósito directo, ésta será efectiva después de una oportunidad razonable para dicho acto.

En el caso que fondos hayan sido depositados erróneamente en mi cuenta, autorizo a CARING HOME HEALTH debitar de mi cuenta(s) dichos fondos sin exceder el monto original del crédito.

Entiendo que CARING HOME HEALTH se reserva el derecho de rechazar cualquier solicitud de depósito directo. También entiendo que todos los depósitos directos se hacen a través de la Cámara de Compensación Automatizada (ACH), y que la disponibilidad de los fondos está sujeta a los términos y limitaciones de la ACH, así como de la institución financiera.

Nota: Si envía este formulario electrónicamente, por favor escriba sus iniciales y los últimos 4 dígitos de su número de seguro social en el campo de firma. Si lo envía por correo o por fax, por favor imprima una copia y firme con su nombre(s) en el cuadro de firma.

Firma del Empleado: _____

Fecha: _____

Employee's! Direct Deposit is a reality for all of us now. We must protect your privacy. In order to send your paystubs securely we will use RAPID! Pay Card process. If you have a Rapid! Pay card you can manage your account by downloading their ap to your cell phone. Follow the instructions below to access your paystub.

Welcome to ePaystub PLUS

To log in to ePaystub PLUS to view your paystubs, please follow the instructions below:

1. Go to <https://www.epaystubplus.com>
2. Type in your SSN as your USER ID
3. Type in your date of birth
4. Your company name will appear in the drop down
5. Your temporary password is the last four digits of your SSN
6. Follow the instructions to reset your password and set your security questions

If you have questions, please call rapid! PayCard Enrollment Team Main Line
(888) 828-2270 ext 2
