CORE PIPE – IL Benefit Universal Enrollment Form

TO BE COMPLETED BY EMPLOYER

Employer Name: Core Pipe Products, Inc.

Reasons for submitting this form:

❑ **New Enrollment** ❑ **Open Enrollment** ❑ **Change**

❑ Benefit Eligibility Date: ____/_____/_____
❑ New Hire
❑ Add Employee/Dependents
❑ Drop Coverage(s)
❑ Increase Life Insurance Policy
❑ No Changes
❑ Termination of Employment Date: ____/_____/_____
❑ Covered on Spouse Insurance Date: ____/_____/_____

Special Enrollment: Date of Event: _____/_____/_____
Reason: ❑ Add EE/ and/or Dependent(s) ❑ Drop EE and/or Dependent(s)
❑ Adoption ❑ Child Court Order ❑ Newborn ❑ Marriage/Civil Union ❑ Divorce/Legal Separation
❑ Loss of Other Coverage ❑ Loss/Gain of Medicare/Medicaid ❑ Other

TO BE COMPLETED BY EMPLOYER - About Employee's Job:

Hours worked per week: _____
Date of Hire: _____/ _____/ _____ Job Title: _____ ❑ Hourly ❑ Salaried

TO BE COMPLETED BY EMPLOYEE

Instructions:
Please complete, sign, date, and return this enrollment form to the Human Resources Department no later than 31 days post hire or following a life event. PLEASE NOTE: Once your enrollment form has been submitted and processed, no changes will be allowed during the current plan year except in the case of a qualifying event. For qualifying life event changes, please provide a copy of documentation confirming the life event.
Information about your benefits may be obtained from the Human Resources Department.

About You:

Employee Legal Name (Last / First / Middle Initial)			Social Security #	
Mailing Address		City	State	Zip
Date of Birth	Home Phone	Cell Phone	E-mail Address	
Gender ❑ Male ❑ Female	Marital Status: ❑ Married ❑ Single Do you have children or other dependents? ❑ Yes ❑ No Are you covered by Medicare? ❑ Yes ❑ No If so, HIC # _____			

About Your Family:
Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, niece or a nephew.

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Spouse (Last / First / Middle Initial)			Social Security #		
❑ **Please complete Spousal Affidavit if covering spouse.**					
Mailing Address (if different than employee)		City	State	Zip	
Date of Birth	Gender: ❑ Male ❑ Female		Phone (optional)	Reason: ❑ Marriage ❑ Divorce/Legal Separation ❑ Other enrollment eligibility	
Child/Dependent 1 (Last / First / Middle Initial)			Social Security #		
Mailing Address (if different than employee)		City	State	Zip	
Date of Birth	Gender: ❑ Male ❑ Female		Phone (optional)	Status (check all that apply) ❑ Disabled ❑ Newborn ❑ Child underage 26	
Child/Dependent 2 (Last / First / Middle Initial)			Social Security #		
Mailing Address (if different than employee)		City	State	Zip	
Date of Birth	Gender: ❑ Male ❑ Female		Phone (optional)	Status (check all that apply) ❑ Disabled ❑ Newborn ❑ Child underage 26	
Child/Dependent 3 (Last / First / Middle Initial)			Social Security #		
Mailing Address (if different than employee)		City	State	Zip	
Date of Birth	Gender: ❑ Male ❑ Female		Phone (optional)	Status (check all that apply) ❑ Disabled ❑ Newborn ❑ Child underage 26	
Child/Dependent 4 (Last / First / Middle Initial)			Social Security #		
Mailing Address (if different than employee)		City	State	Zip	
Date of Birth	Gender: ❑ Male ❑ Female		Phone (optional)	Status (check all that apply) ❑ Disabled ❑ Newborn ❑ Child underage 26	

Please put a check mark in the appropriate box

Benefits			**Enroll**							
Plan options	**Cancel**	**Waive***	**EE only**	**EE + Sp**	**EE+ Child (ren)**	**Family**	**Plan Type**			
UHC - Medical (must select plan type)	❑	❑	❑	❑	❑	❑	❑ Core PPO w/ HRA DOZH	❑ Core PPO HDHP w/ HSA ECJE	❑ Navigate w/ HRA HMO DOWJ **Must choose PCP	❑ Charter HMO DOW7 **Must choose PCP
Dental	❑	❑	❑	❑	❑	❑				
Vision	❑	❑	❑	❑	❑	❑				
Basic Life	❑	❑	❑	❑	❑	❑	Complete Beneficiary Form page 4			
Voluntary Life	❑	❑	❑	❑	❑	❑	If electing, you must fill out page 5 and 6 if applicable			
Voluntary Accident	❑	❑	❑	❑	❑	❑				
Voluntary Critical Illness	❑	❑	❑	❑	❑	❑	If electing, you must fill out the bottom of page 3			
Vol. Hospital Indemnity	❑	❑	❑	❑	❑	❑				

*I understand that selecting waive means I will not be enrolled in coverage.

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** If enrolling in an HMO plan you must list your Primary Care Physician(s) (PCP) Name & ID number below:

Employee:

PCP Name _____

PCP Name _____

Spouse:

PCP Name _____

PCP Name _____

Child(ren):

PCP Name _____

PCP Name _____

TO BE COMPLETED BY EMPLOYEE (continued)

MEDICAL - United Healthcare (UHC)

❑ Plan election change **NOTE: If dropping HDHP with HSA submit a direct deposit form to the Payroll Mgr. to cancel your HSA deduction.**

VOLUNTARY CRITICAL ILLNESS – United Healthcare (UHC)

❑ I do NOT elect to participate in the Critical Illness coverage.

❑ I elect to participate in the Critical Illness plan. (Please fill in remainder of this section)

Employee $10,000; Spouse $10,000; Child $5,000

Critical Illness	Employee	Employee and Spouse	Employee and Child(ren)	Family
Under 25				
25-29				
30-34				
35-39				
40-44				
45-49				
50-54				
55-59				
60-64				
65-69				
70-74				
75+				

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BASIC LIFE/AD&D – UnitedHealthcare

Benefit reductions apply. Please see plan administrator for questions.

Policy Amount: $25,000 Hourly and $50,000 Salaried UnitedHealthcare - **Employee Only: AUTO-ENROLLED**

Name your Primary Beneficiaries (Primary beneficiary percentages must total 100%)

Primary Beneficiary Name:	Social Security Number:		_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

Primary Beneficiary Name:	Social Security Number:		_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

Primary Beneficiary Name:	Social Security Number:		_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

Primary Beneficiary Name:	Social Security Number:		_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

*Name your Contingent Beneficiary

Contingent Beneficiary Name:	Social Security Number:		_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

Contingent Beneficiary Name:	Social Security Number:		_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

*In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.

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VOLUNTARY LIFE – United Healthcare (UHC)

Employee Voluntary Life Amount

You must be enrolled to cover your dependents. Benefit reductions apply.

❑ I choose to waive Voluntary Life coverage.

❑ I choose to participate in the Voluntary Life Plan. (Please mark box to the left and fill in remainder of this section)

Additional Life Requested Amount: $_____

(Minimum $10,000 with maximum of $500,000 in $10,000 increments – Guarantee Issue amount is $100,000)

An Evidence of Insurability (EOI) must be completed if any amount above the Guarantee Issue Amount is elected or if previously declined. Please see HR for an EOI form.

Spouse Voluntary Life Amount

Benefit reductions apply. Please see plan administrator.

❑ I choose to waive this Spousal coverage.

❑ I choose to elect Voluntary Life for my spouse (Please mark box to the left and fill in remainder of this section)

The amount may not be more than 100% of the employee amount for Voluntary Life.

Spousal Life Requested Amount: $_____

Spouse coverage terminates when you reach age 70.

An Evidence of Insurability (EOI) must be completed if any amount above the Guarantee Issue Amount is elected or if previously declined. Please see HR for an EOI form.

Dependent/Child(ren) Voluntary Life Amount - 14 days to age 26

You must be enrolled to cover your child(ren).

❑ I choose to waive this Dependent/Child(ren) Voluntary Life coverage.

❑ I choose to elect Voluntary Life for my Dependent/Child(ren) (Please mark box to the left and fill in remainder of this section)

Dependent Life Requested Amount: $_____

(Minimum $2,000 with maximum of $10,000, in $1,000 increments)

TO BE COMPLETED BY EMPLOYEE (continued)

Name your Voluntary Life Primary Beneficiaries: If electing different beneficiaries that are not the same as those named for Basic Life, please name below. *(Primary beneficiary percentages must total 100%)*

Primary Beneficiary Name:		Social Security Number:	_____%
Mailing Address:	City:	State:	Zip:
Date of Birth:	Phone:	Relationship to Employee:	

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Primary Beneficiary Name:			Social Security Number:		_____%
Mailing Address:	City:		State:	Zip:	
Date of Birth:		Phone:	Relationship to Employee:		

*Name your Contingent Beneficiary

Contingent Beneficiary Name:			Social Security Number:		_____%
Mailing Address:	City:		State:	Zip:	
Date of Birth:		Phone:	Relationship to Employee:		

Contingent Beneficiary Name:			Social Security Number:		_____%
Mailing Address:	City:		State:	Zip:	
Date of Birth:		Phone:	Relationship to Employee:		

*In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.

Please Sign Below

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet).This does not apply to eligible retirees.
- If Voluntary life coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. UnitedHealthcare, or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing a thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits to a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Signature of Employee: _____ **Date:** _____