SILVER LAKE HOSPITAL

Universal Enrollment Form

Effective Date: _____

☐ New Hire ☐ Qualified Life Event ☐ Rehire ☐ Open Enrollment

Section 1 — Employee General Information				Class Tier 1
Employee's Last Name	First Name			Middle Initial
Street Address	City	State	Zip	Telephone Number

Date of Birth (MM/DD/YYYY)	Gender	Marital Status	Social Security Number (required)
	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated	

Section 2 — UHC Medical — Medical & Prescription Drug Payroll/Coverage Election

Please confirm your bi-weekly payroll deduction for the 2025 plan year

UHC Medical/Rx	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
NexusACO Open Access Plan	☐ $62.16	☐ $216.54	☐ $172.08	☐ $247.42

I decline Medical/Prescription Drug benefits for the following reason:

☐ I have coverage through my spouse's employer ☐ I have coverage via Medicare or Medicaid

☐ I have coverage via the Marketplace Exchange (Affordable Care Act) ☐ I cannot afford coverage

I understand that if I decline now I will not be able to enroll until next open enrollment.
(You must also provide a signature on last page of this Form even if you are waiving all benefits)

Section 3 — UHC — Dental Payroll Election

Please confirm your bi-weekly payroll deduction for the 2025 plan year

UHC Dental	Employee Only	Employee + 1	Employee + 2 or more
DMO	☐ $6.04	☐ $13.16	☐ $20.30
DPPO	☐ $23.14	☐ $43.96	☐ $69.43

☐ **I decline dental benefits at this time**

I understand that if I decline now I will not be able to enroll until next open enrollment.
(You must also provide a signature on last page of this Form even if you are waiving all benefits)

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Section 4 — VSP (Vision Service Plan)—Vision Payroll Election

Please confirm your bi-weekly payroll deduction for the 2025 plan year

VSP	Employee Only	Employee + 1	Employee & Children	Employee & Family
Voluntary Vision	☐ $4.13	☐ $6.60	☐ $6.74	☐ $10.87

☐ **I decline vision benefits at this time**

I understand that if I decline now I will not be able to enroll until next open enrollment.

(You must also provide a signature on last page of this Form even if you are waiving all benefits)

Section 5 — Dependent Enrollment Information

First & Last Name	Gender	Relationship (as stated by criteria in Section 5)	Date of Birth (MM/DD/YYYY)	Social Security # (Required)	Is this dependent disabled?	Select Plan(s) for Enrollment
	☐ M ☐ F	☐ Spouse ☐ Child			☐ Yes ☐ No	☐ Medical/Rx ☐ Dental ☐ Vision
	☐ M ☐ F	☐ Spouse ☐ Child			☐ Yes ☐ No	☐ Medical/Rx ☐ Dental ☐ Vision
	☐ M ☐ F	☐ Spouse ☐ Child			☐ Yes ☐ No	☐ Medical/Rx ☐ Dental ☐ Vision
	☐ M ☐ F	☐ Spouse ☐ Child			☐ Yes ☐ No	☐ Medical/Rx ☐ Dental ☐ Vision

Section 6— Primary Care Physician (PCP) Selection

First & Last Name	PCP Name	PCP Office ID Number
SELF		

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Section 7 — Medicare Information (Complete ONLY if applicable)

Are you, your spouse, or dependent child Medicare eligible? ☐ Yes ☐ No

If **Yes**, provide Member Name, Relationship, Medicare Number and Effective Date of Part A and Part B:

Member Name	Relationship	Medicare Number

Effective Date of Part A	Effective Date of Part B

Section 8 — Other Insurance (Complete ONLY if applicable)

Is any person listed on this enrollment form currently covered by another health plan, HMO, or Medicare? ☐ Yes ☐ No

If **Yes**, please provide the following information:

Policyholder Name	Phone Number of Other Insurer

Name and Address of Other Insurance Company

Policy Number	Effective Date of Policy (MM/DD/YYYY)	Termination Date of Policy (MM/DD/YYYY)

Does this policy cover:	Is this coverage under COBRA?	List the names of the spouse and/or child(ren) covered:
☐ You ☐ Your Spouse ☐ Your Child(ren)	☐ Yes ☐ No	

Section 9 — Dependent Eligibility Certification

By signing this Certification Section, I confirm that all the dependents I am enrolling for coverage listed in Section 6 of this Form meet the following definition of dependent:

- If I have provided spouse's information for enrollment, I attest they are a lawful spouse, to whom I am legally married.
- If I have provided child(ren) information for enrollment, I attest they are:
  - less than 26 years old; or
  - 26 or more years old an primarily supported by me and incapable of self-sustaining employment by reason on mental or physical handicap (note there is a separate form that must be completed and submitted to Aetna)
  - I understand that a dependent child under age 26 will qualify for the Medical/Rx & Vision Plan until the end of the month in which they reach age 26.
  - I understand that a dependent child under age 26 will qualify for the Dental Plan until the end of the month in which they reach age 26.

Employee Name (print) Employee Signature Date

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Section 10 — Beneficiary Information— Basic Life/AD&D

Provided to all benefit-eligible employees at no cost

In accordance with the conditions of the Group Policy listed above, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies) (if any) and designate as primary beneficiary(ies) and contingent beneficiary(ies) (if any) in the event of the insured's death, the following:

Important Note: Employees cannot designate themselves as a beneficiary. Please be sure to list an appropriate beneficiary.

PRIMARY BENEFICIARY DESIGNATION

Your primary beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds. You may have the proceeds divided among several primary beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				100%

In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies):

CONTINGENT BENEFICIARY DESIGNATION

Your contingent beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds if your primary beneficiary(ies) (see definition above) predecease (s) the insured. You may have the proceeds divided among several contingent beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				100%

SECTION 11 — Signature and Verification (your application cannot be processed without your signature)

I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge. I understand that providing false information or concealing information for the purpose of misleading, to any insurance company, is subject to criminal and civil penalties. I understand that IRS §125 prohibits me from changing my enrollment during the Plan Year unless I experience a qualifying life event. A qualifying event includes a marriage, divorce, death of a spouse or a dependent, birth or adoption of a child, termination, or commencement of employment for your spouse, a change in employment status (full-time to part-time or part -time to full-time) for you or your spouse that affects benefits eligibility, or taking an unpaid, medical leave of absence by either you or your spouse. If you experience one of these qualifying events, you are obligated to notify the Human Resources Department within 30 days. Failure to do so may affect benefits coverage.

Employee Name (print) Employee Signature Date