Housing BenefitsPlan
Sponsored by SERC/SWRC
medical•dental•vision•life•long term disability

Enrollment and Change Form

Please print or type clearly in blue or black ink.

EMPLOYER SECTION: Please complete for employee

Agency Name _____ Agency State _____ Billing Account # _____

Check One:
☐ New Enrollment ☐ Addition ☐ Change
☐ Voluntary Cancellation ☐ Non-Voluntary Cancellation ☐ Other _____

Date of Hire _____ Effective Date of Change _____

Type of Change _____ Reason for Change _____

Employee Information

_____ _____ _____
Name (Last, First, Middle Initial) Date of Birth Social Security Number

_____ _____ _____ _____
Address City State Zip Code

Gender:
☐ Male
☐ Female

Marital Status:
☐ Married
☐ Not Married

Employment Status:
☐ Active Employee
☐ Retiree

MEDICAL PLAN ELECTION (check one)

☐ Premier PPO ☐ Premier Plus PPO
☐ Value PPO ☐ Value PPO w/ Premier Rx
☐ Out of Area
☐ Not applicable (Benefit not offered by authority)

MEDICAL COVERAGE TIER (check one)

☐ Employee ☐ Employee & Spouse
☐ Employee & Children ☐ Family
☐ Coverage Waived

BASIC LIFE / AD&D INSURANCE (check one)

☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 Other $_____
☐ Not applicable (Benefit not offered by authority)

OPTIONAL DEPENDENT LIFE INSURANCE:

☐ $2,000 for Spouse and $1,000 per child
☐ Not applicable (Benefit not offered by authority)

Beneficiary/Beneficiaries (Last, First, Middle Initial)	% of Benefit	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

DENTAL PLAN ELECTION (check one)	**DENTAL COVERAGE TIER** (check one)
☐ UHC Dental Plan ☐ Not applicable (Benefit not offered by authority)	☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family ☐ Coverage Waived

VISION PLAN ELECTION (check one)	**VISION COVERAGE TIER** (check one)
☐ UHC VISION **www.myuhcvision.com** ☐ VSP VISION **www.vsp.com** ☐ Not applicable (Benefit not offered by authority)	☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family ☐ Coverage Waived

LONG TERM DISABILITY (check one)

☐ Class 1 - Executive Directors
☐ Class 2 - All other employees
☐ Coverage Waived
☐ Not applicable (Benefit not offered by authority)

Monthly Salary $_____

Occupation _____

DEPENDENT INFORMATION

Please list all eligible family members to be enrolled in medical dental and/or vision coverage. Add separate sheet if necessary

Dependent Full Name	Gender	Date of Birth	Social Security #	Relationship	Medical	Dental	Vision
_____	_____	_____	_____	_____	☐	☐	☐
_____	_____	_____	_____	_____	☐	☐	☐
_____	_____	_____	_____	_____	☐	☐	☐
_____	_____	_____	_____	_____	☐	☐	☐

AUTHORIZATION

** I accept the coverage provided by **Housing Benefits Plan** and authorize deductions from earnings of the required contributions, if any, towards the cost of my coverage. This authorization applies only if employee contributions are required.

** Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

** I understand and acknowledge that **Housing Benefits Plan** is a tax qualified voluntary employees' beneficiary association sponsored by SERC-NAHRO & SWRC-NAHRO and not by my employer. I further acknowledge and agree that **Housing Benefits Plan** is subject to the provisions of the Internal Revenue Code and ERISA.

** I hereby certify that the foregoing information is true and correct to the best of my knowledge and accept the provisions above.

** I have read and understand the eligibility rules and represent and warrant the people I have enrolled are eligible.

_____ _____

Employee Signature Date

ENROLLMENT SUBMISSION

If submitting this form via email, the form **MUST** be submitted to the following email address: HBP@vimly.com

If you have questions regarding the submission of this enrollment form, please contact Vimly Customer Service by email (HBP@vimly.com) or by telephone (833) 570-5404.

EE Enrollment Form

Rev.10.2022