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 _____

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 ☐ High Deductible Plan
☐ Coverage Waived
☐ Not applicable (Benefit not offered by authority)

MEDICAL COVERAGE TIER (check one)

☐ Employee ☐ Employee & Spouse
☐ Employee & Children ☐ Family

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
☐ Coverage Waived
☐ Not applicable (Benefit not offered by authority)

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

DENTAL PLAN ELECTION (check one)

- ☐ UHC Dental Plan
- ☐ Coverage Waived
- ☐ Not applicable (Benefit not offered by authority)

DENTAL COVERAGE TIER (check one)

- ☐ Employee
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Family

VISION PLAN ELECTION (check one)

- ☐ UHC VISION www.myuhcvision.com
- ☐ VSP VISION www.vsp.com
- ☐ Coverage Waived
- ☐ Not applicable (Benefit not offered by authority)

VISION COVERAGE TIER (check one)

- ☐ Employee
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Family

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 _____

SHORT-TERM DISABILITY (check one)

- ☐ Short-Term Disability
- ☐ Coverage Waived
- ☐ Not applicable (Benefit not offered by authority)

Monthly Salary $_____

Occupation _____

Age _____

ACCIDENTAL INJURY (check one)

- ☐ Plan 1
- ☐ Plan 2
- ☐ Coverage Waived
- ☐ Not applicable (Benefit not offered by authority)

ACCIDENTAL INJURY COVERAGE TIER (check one)

- ☐ Employee
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Family

CRITICAL ILLNESS (check one)

- ☐ $10,000 Benefit Amount
- ☐ $20,000 Benefit Amount
- ☐ Coverage Waived
- ☐ Not applicable (Benefit not offered by authority)

CRITICAL ILLNESS COVERAGE TIER (check one)

- ☐ Employee
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Family

Employee's Age _____

HOSPITAL CARE (check one)

- ☐ Plan 1
- ☐ Plan 2
- ☐ Coverage Waived
- ☐ Not applicable (Benefit not offered by authority)

HOSPITAL CARE COVERAGE TIER (check one)

- ☐ Employee
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Family

DEPENDENT INFORMATION

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

Dependent Full Name	Gender	Date of Birth	Social Security #	Relationship	Medical	Dental	Vision	Accident	Crit. Ill	Hospital
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

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 FORM SUBMISSION

This form can be used to submit enrollments and changes into the SIMON365 platform. This form should be kept as backup in the employee's file. If submitting this form in lieu of making the changes in SIMON365, the form **MUST** be submitted to the following email address: HBP@vimly.com For questions regarding the submission of this enrollment form, please contact Vimly Benefit Solutions' customer service by email (HBP@vimly.com) or by telephone (833) 570-5404.