North Kansas City Hospital

Benefits Enrollment Form - 2020

EMPLOYEE INFORMATION: **Employee ID #** _____

Date of Hire _____ **Date of Birth** _____ **Scheduled Hours / Pay Period** _____

Employee Name _____ **Social Security Number** _____/_____/_____

Street Address _____ **City** _____ **STATE** _____ **ZIP** _____

Home Phone _____ **Effective Date:** _____

***Reason for change** _____

BlueSelect Plus Kansas City Health Plan	MetLife Dental Plan	MetLife Vision Plan	navia Flexible Spending Plan
☐ Traditional Plan $1000 deductible ☐ High Deductible Plan $2750 deductible $ 45.58 ☐ Employee $27.96 $ 99.19 ☐ Employee + Child(ren) $64.65 $ 112.60 ☐ EE +Spouse $83.87 $ 169.46 ☐ Family $112.20 ☐ Decline Entire Benefit Other Health Coverage ☐ Yes ☐ No If Yes, please attach a copy of the card.	☐ Dental Basic ☐ Dental Limited $7.17 ☐ Employee $5.05 $18.17 ☐ Employee + Child(ren) $14.97 $19.79 ☐ EE +Spouse $15.66 $34.18 ☐ Family $24.28 ☐ Decline Entire Benefit	☐ Vision $3.83 ☐ Employee $7.41 ☐ Employee + Child(ren) $7.68 ☐ EE +Spouse $11.39 ☐ Family ☐ Decline Entire Benefit	☐ Medical – FSA ☐ Decline Entire Benefit Amount $ _____ per year (Annual Maximum $2,650) ☐ Dependent Care/Day Care - FSA ☐ Decline Entire Benefit Amount $ _____ per year (Annual Maximum $5,000)

Please list eligible dependents you wish covered under the Health, Dental or Vision plans

HEALTH	DENTAL	VISION	*	First Name MI Last Name	Add to Plan	Remove from Plan	Sex M / F	Birthday mm/dd/yy	Age	Social Security Number
			E							/ /
			S							/ /
			C							/ /
			C							/ /
			C							/ /
			C							/ /
			C							/ /
			C							/ /
			C							/ /

*E = Employee S = Spouse C = Child

Signature _____ **Date** _____/_____/_____

I hereby certify that all information supplied by me is true. I have read and agree with the above terms, and I accept the provisions on the reverse side of this form which I have read and understand.

PROVISIONS

I accept the coverage/insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form.

I authorize any participating office to release records and billing information concerning me or my dependents to our benefit vendors for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize NKCH to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.

I authorize payment of benefits to the participating provider.

Copies of each Plan Document may be found on the Hospital Intranet and are available in Human Resources. Contact Human Resources 816-691-2061 option 3 for a benefit representative.

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information, or who conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty.