

2021-2022 Enrollment Form

Open Enrollment 2021-22 **Effective Date: October 1st, 2021** **Division: 001 MSNW/002 Mennonite**

Mennonite Services Northwest & Mennonite Village

This is your 2021-22 Enrollment form. It provides you with information about your core benefits and the optional benefits you may elect, as well as the per payroll cost of each of the options. **Indicate your benefit choice for each of the coverage's by circling both the benefit option and the cost of the option.** To help you calculate your total cost, you may enter the cost of each option you select on the line to the right. **How healthcare reform affects your plan:** In March 2010, President Obama signed the Patient Protection and Affordable Care Act, or PPACA, into law. PPACA, also known as health care reform includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services w/out cost sharing.

Personal Data

Name: _____
 Address: _____
 Phone #: _____
 Email: _____
 DOH: _____
 DOB: _____
 SS #: _____
 Dept: _____
 Gender: Male Female
 Marital Status: Married Single

Check box of plan enrolling in or if declining

	<u>Employee</u>	<u>Children</u>		
Core Medical	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$759.87	<input type="checkbox"/> Decline	Total \$
Value Medical	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$652.07		

ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE YES NO (ie. Medicare, spouse's plan, market)
Please attach a copy of your insurance card (You must provide proof of other insurance to decline medical benefits)

check only if asking for exception **I qualify for an exemption: Due to a medical condition that prevents me from participating in a wellness program. I understand to qualify for this exemption I may be asked to provide written documentation from my healthcare provider.**

Vision:

Please Check one box

VSP	<u>Employee</u>	<u>Spouse</u>	<u>Children</u>	<u>Family</u>		
	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$3.55	<input type="checkbox"/> \$3.75	<input type="checkbox"/> \$9.68	<input type="checkbox"/> Decline	Total \$

Dental Options: (cost to employee p/mo.)

Please Check one box

	<u>Employee</u>	<u>Spouse</u>	<u>Children</u>	<u>Family</u>		
MODA Dental - Low	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$31.47	<input type="checkbox"/> \$54.64	<input type="checkbox"/> \$86.09		
MODA Dental - High	<input type="checkbox"/> \$28.34	<input type="checkbox"/> \$86.57	<input type="checkbox"/> \$97.37	<input type="checkbox"/> \$155.55		
Willamette Dental - Low	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$29.55	<input type="checkbox"/> \$51.25	<input type="checkbox"/> \$80.75		
Willamette Dental - High	<input type="checkbox"/> \$28.10	<input type="checkbox"/> \$84.25	<input type="checkbox"/> \$94.65	<input type="checkbox"/> \$150.75	<input type="checkbox"/> Decline	Total \$

FSA and HRA:

FSA:	Bi-weekly	Annual
Total Health contributions (maximum allowed \$2750)	\$ _____	\$ _____
Total dependent care contributions (\$2,500 single/\$5,000 joint max)	\$ _____	\$ _____

HRA you can choose one option for the plan year

HRA (Co. Paid)	\$1,200	<input type="checkbox"/>	Co. Paid FSA Dependent Care	\$1,200	<input type="checkbox"/>
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Authorization:

I apply for the benefit options on this enrollment form. I authorize Mennonite Village, if necessary, to reduce my pre-tax salary to pay for the options I have elected and authorized Mennonite Village to deduct on an after tax basis any after tax option chosen. In addition, the amount of my salary reduction may be increased or decreased by Mennonite Village during the Plan Year if the cost of my portion of the premium increases or decreases due to a change in my employment status. I realize that I will be responsible for my portion of the cost of coverage; even if I do not receive a paycheck. I understand that I will forfeit credits/dollars remaining in the FSA over \$500 & any unused HRA account at the end of the plan year that have not been used for reimbursement or eligible plan expenses incurred during the plan year. Any previous Election and Compensation Reduction Agreement relating to medical, dental and flexible spending accounts, is hereby revoked.

All information provided by me on any enrollment forms is true to the best of my knowledge. I have read and understand the above authorization and agree to have Mennonite Village reduce my salary as selected above.

Signature _____ Date _____

Family Information cont.**(List All Family Members Covered)**

Add Dependent Date: _____ Reason _____ Term Dependent Date: _____ Reason _____

Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male

Female

Spouse: Other coverage Y N

Medical

Domestic Partner Other coverage Y N

Dental

Dependent: Other coverage Y N

Vision

Add Dependent Date: _____ Reason _____ Term Dependent Date: _____ Reason _____

Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male

Female

Medical

Spouse: Other coverage Y N

Dental

Domestic Partner Other coverage Y N

Vision

Dependent: Other coverage Y N

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.* Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory report dental records, or hospital records (including nursing records and progress notes.)

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. Moda can provide a copy by calling the Privacy Office at 503-243-4492.

Important Note: Dependent coverage is now available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee's biological, step, foster or adopted child (including a child placed for adoption) until such child reaches age 26 for medical & dental and age 25 for vision.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if required fields are not filled out entirely.

Signature _____

Date _____

Carrier Information: Plan Name, Group #, address

Medical:	MSNW #14173	Meritain, Aetna, MagellanRx, DirectPath	PO Box 27810 Minneapolis MN 55427-0267
Vision:	Vision Services Plan # 30017615		3333 Quality Drive, Rancho Cordova CA 95670
Dental:	Delta Dental of Oregon #10001924		Moda Tower 601 SW 2nd Ave Portland OR 97204
Dental:	Willamette Dental Insurance, Inc #OR85		6950 NW Campus Way Hillsboro OR 97124
FSA/HRA:	QVI Risk Solutions, Inc		PO Box 7199 Bend OR 97708

Family Information**(List All Family Members Covered)**
 Add Dependent Date: _____ **Reason** _____ **Term Dependent Date:** _____ **Reason** _____

Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male Female Medical Dental Vision Spouse: Other coverage Y NDomestic Partner Other coverage Y NDependent: Other coverage Y N
 Add Dependent Date: _____ **Reason** _____ **Term Dependent Date:** _____ **Reason** _____

Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male

Female

Medical Dental Vision Spouse: Other coverage Y NDomestic Partner Other coverage Y NDependent: Other coverage Y N
 Add Dependent Date: _____ **Reason** _____ **Term Dependent Date:** _____ **Reason** _____

Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male

Female

Medical Dental Vision Spouse: Other coverage Y NDomestic Partner Other coverage Y N**Dependent:** **Other coverage Y N**
 Add Dependent Date: _____ **Reason** _____ **Term Dependent Date:** _____ **Reason** _____

Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male Female Medical Dental Vision Spouse: Other coverage Y NDomestic Partner Other coverage Y NDependent: Other coverage Y N
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Last Name: _____

First Name: _____

Social Security Number: _____

DOB: _____

Male Female Medical Dental Vision Spouse: Other coverage Y NDomestic Partner Other coverage Y NDependent: Other coverage Y N

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if required fields are not filled out entirely.

Signature _____

Date _____