2022-23 Enrollment Form

☐ **Open Enrollment** **Effective Date: October 1st, 2022** **Division: 001 MSNW/002 Mennonite Village**

Mennonite Services Northwest & Mennonite Village

This is your 2022-23 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

	Employee	Children		
Core Medical	☐ **$110.00**	☐ **$762.68**	☐ **Decline**	Total $
Value Medical	☐ **$55.00**	☐ **$650.51**		

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**

	Employee	Spouse	Children	Family		
VSP	☐ **$0.00**	☐ **$4.02**	☐ **$4.24**	☐ **$10.96**	☐ **Decline**	Total $

Dental Options: (cost to employee p/mo.) **Please Check one box**

	Employee	Spouse	Children	Family		
MODA Dental - Low	☐ **$0.00**	☐ **$31.47**	☐ **$54.64**	☐ **$86.10**		
MODA Dental - High	☐ **$28.34**	☐ **$86.58**	☐ **$97.36**	☐ **$155.56**		
Willamette Dental - Low	☐ **$0.00**	☐ **$31.30**	☐ **$54.26**	☐ **$85.50**		
Willamette Dental - High	☐ **$29.75**	☐ **$89.20**	☐ **$100.20**	☐ **$159.66**	☐ **Decline**	Total $

FSA and HRA:

FSA:	**Bi-weekly**	**Annual**
Total Health contributions (maximum allowed $2850)	$	$
Total dependent care contributions ($2,500 single/$5,000 joint max)	$	$

Choose one of the Company paid options:

Co. Paid HRA $1,200 ☐ **Co. Paid FSA Dependent Care** $1,200 ☐

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 $570 & 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 _____

**Complete other side of form if covering any dependents.

Family Information cont. **List All Family Member that will be 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

[ ] 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 [ ]

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 ernollment 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 requred 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 faciltiy;
- Any other instituion 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, corresondence, 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 disclosers, 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, Rncho 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:	Rocky Mountain Reserve	PO Box 631458, Littleton CO 80163	

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Family Information **List All family members that will be covered**

[ ] 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

[ ] 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**

[ ] 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	[ ]	Spouse:	[ ]	Other coverage	Y N
Medical	[ ]	Domestic Partner	[ ]	Other coverage	Y N
Dental	[ ]	Dependent:	[ ]	Other coverage	Y N
Vision	[ ]				

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

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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_____

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Social Security Number: DOB: _____

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Female

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Dental [ ] Domestic Partner [ ] Other coverage Y N

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