|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMPLOYEE INFORMATION** | | | | | | | | | | | |
| Last Name: | | | | First Name: | | | | | | Middle Initial: | |
| Street Address: | | | | | City: | | | | State | Zip | |
| Cell Phone  ( ) | | Home Phone  ( ) | | | | | Email Address: | | | | |
| Social Security Number: | | | | | Birth Date: | | | | | Date: | |
| **HEALTH INSURANCE** | | | | | | | | | | | |
| **PRIORITY HEALTH HMO HRA 80-1**  Hospital Coverage  Office Visit Co-Pay  Medical Deductible *- (JDX pays 100%)*  Rx Co-Pay  Contraceptives  Rx Deductible  OOP Individual / Family  Emergency Room Co-Pay  Ambulance Co-Pay  Domestic Partner | | 80% Coinsurance  $20 / $35 / $75  $1,000 / $2,000  $15 / $50 / $80  20% / 20%  Non-Exempt  N/A  $1,500 / $3,000  $150  $150  No | | | | Option | | | Monthly | Weekly | Deduction |
| Single | | | $275.08 | $63.48 | $ |
| Double | | | $605.17 | $139.65 | $ |
| Family | | | $756.46 | $174.57 | $ |
| No Coverage | | | Complete Waiver | | |
| New Coverage | | | Complete Enrollment Form | | |
| **DENTAL INSURANCE** | | | | | | | | | | | |
| **HUMANA DENTAL**  Plan  Periodontal / Endodontic  Deductable  Annual Max  Optional Benefits | | MI Trad Pref X  100/50/50 In  100/50/50 out  Basic  $50 / $50  $1,500  $1,000 Child Ortho,  Ded Waived on Preventive | | | | Option | | | Monthly | Weekly | Deduction |
| Single | | | $ 28.27 | $ 6.52 | $ |
| Double | | | $ 63.61 | $ 14.68 | $ |
| Emp & Children | | | $ 61.51 | $ 14.19 | $ |
| Family | | | $ 98.86 | $ 22.81 | $ |
| New Coverage | | | Complete Enrollment Form | | |
| **LIFE INSURANCE** | | | | | | | | | | | |
| **HARTFORD *(Paid by JDX 100%)*** | | | New or Continued Coverage | | | | | Completed Beneficiary Form | | | |
| **AUTHORIZATION** | | | | | | | | | | | |
|  | I do not wish to participate in either the Health Insurance or the Dental Insurance offered through Jack Dykstra Excavating during this time of Open Enrollment. I understand that I will not be eligible for coverage until Jack Dykstra Excavating has its next Open Enrollment period, unless I qualify for coverage due to a HIPAA qualifying event (such as marriage, birth of a child, adoption, or loss of other coverage) | | | | | | | | | | |
|  | I authorize Jack Dykstra Excavating to deduct from my paycheck as pre-tax amounts the employee premiums indicated above relative to Health Insurance and Dental Insurance I have selected. | | | | | | | | | | |
| Employee Signature | | | | | | | | | | | Date |