eamc
east alabama medical center
2000 Pepperell Parkway
Opelika, AL 36801

eamc LANIER
east alabama medical center
4800 48th Street
Valley, Al 36854

EAMC and EAMC-Lanier
Benefit Enrollment Form

Please complete this form to indicate whether you wish to enroll in coverage or wish to decline coverage in each of the benefit options listed. Please use an ink pen and print your answers. If boxes are provided indicate your answer with a check mark **(✓).**

After completing this application for coverage due to a qualifying life event or a new hire **under the EAMC Health Plan**, please make sure that you complete the Gaps in Care that apply to you or your spouse to ensure that you qualify for the lowest health insurance premium next year. Gaps in Care only apply to you and/or your spouse. For more information about Gaps in Care please call Human Resources at (334) 528-4188 or call Blue Cross Blue Shield of Alabama at 1-866-888-6934.

East Alabama Medical Center
East Alabama Medical Center – Lanier

1. Enter this information about yourself (EMPLOYEE):

Last	First	M.	Social Security Number	Employee Number

Street Address	Date of Birth	Date of Hire/Eligibility	Title

City	State	Zip	Phone Number	Male	Female
				☐	☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Check One: ☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss

2. Dependent Information (Complete if electing family medical/prescription drug, dental, or vision coverage)

List all dependents you wish to cover*

Last	First	Social Security Number	Relationship	Date of Birth
			☐ Husband ☐ Wife	
			☐ Son ☐ Daughter	
			☐ Son ☐ Daughter	
			☐ Son ☐ Daughter	
			☐ Son ☐ Daughter	

3. Medical/Prescription Drug and Dental Coverage

Medical Option	Effective Date:	☐ Employee Only	☐ Employee & Family	☐ Decline
Dental	Effective Date:	☐ Employee Only	☐ Employee & Family	☐ Decline

Coordination of Benefits (COB) ***(If you or your dependents are covered by any other group health insurance)***

Name of Contract Holder	Policy, ID, Contract, or Certificate Number	Type of Coverage ☐ Individual ☐ Family	Insurance Company

Employee's Name	Employee's City	Group Number	Street Address

Name of Participant Entitled to Medicare	☐ Part A ☐ Part B	Medicare Number	City / State / Zip

4. Healthcare Reimbursement Account *($260 minimum annual deduction, $2,750 maximum annual deduction)*

Amount to be deducted each pay period	Annual election:	☐ Decline

5. Dependent Care Reimbursement Account *($260 minimum annual deduction, $5,000 maximum annual deduction)*

Amount to be deducted each pay period	Annual election:	☐ Decline

6. Vision Coverage

	Effective Date:	☐ Employee Only	☐ Employee & Family	☐ Decline

7. Term Life Insurance Plan Beneficiary(ies) (Basic life insurance is automatic for Full-Time and FLEX employees on the first day of the month after 30 days of employment). New hires are eligible to enroll in up to $300,000 in Term Life Insurance. Spouses are eligible to enroll in half of what the employee enrolls in. The Guaranteed Issue amount for spouse coverage is $50,000. Any amount over this will be subject to an Evidence of Insurability. The Guaranteed Issue amount for enrollments outside of new hires/newly eligible employees is $20,000 for employees and $10,000 for spouse coverage. Instructions will be sent to your EAMC email address on how to complete this EOI process online through Lincoln Financial. Please go into INFOR and add the beneficiaries that you would like for your life insurance policy. See the back of this form for important instructions about naming a beneficiary.

Supplemental Life Coverage

	Coverage Amount	Premium	Accept	Decline
Employee	$	$	☐	☐
Spouse (Up to ½ of employee's coverage)	$	$	☐	☐
Child(ren)	$5,000	$0.42	☐	☐

List all dependents eligible under this contract Last First M.	Social Security Number	Relationship	Date of Birth
		SPOUSE	
		☐ Son ☐ Daughter	
		☐ Son ☐ Daughter	
		☐ Son ☐ Daughter	
		☐ Son ☐ Daughter	

8. Short Term Disability (Lincoln – Group Policy #000010196686)

Request for coverage -- If you decline coverage and choose to enroll at a later date, and if a physical examination or further medical information is required, it will be at your own expense.	
☐ I choose to ENROLL in the Short Term Disability insurance	☐ I choose to DECLINE the Short Term Disability insurance at this time

9. Signatures

Please enroll me in the benefits I have selected above. I understand payroll deductions will be made for those benefits, and I authorize EAMC to deduct the amounts from my salary or wages. If I declined any benefits, I understand that I have been given the opportunity to participate in the above benefit plans and that I do not wish to enroll in the plan(s) as indicated. I understand that I cannot change this election until the next open enrollment period unless I experience a qualified status change or if I am changing the beneficiary in Section 7. I understand that I must contact Human Resources within 30 days of a qualified status change.

Blue Cross and Blue Shield of Alabama (BCBS) statement: Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. BCBS may take back any monies paid for me or my family and pay no more if BCBS finds that I did not tell the complete truth.

I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law, including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until BCBS accepts this application in writing. If accepted, I will receive an ID card from BCBS.

I ask my doctor, hospital or anyone else to give all medical records of me or my family to BCBS. BCBS may release those records to anyone necessary to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as BCBS needs to decide about this application and process any of our claims.

I will cooperate with BCBS. If BCBS needs information about other health policies I have, including payments by them, I will give it to BCBS. If BCBS needs information to help subrogate (substitute for me or a family member) or be reimbursed, I will give it to BCBS. I understand that I must follow the directions of my Primary Care Physician to receive the full contract benefits. I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

Employee Signature: _____ **Date:** _____

Important Disclosure Notice

Notice to Individuals Declining Health Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans and issuers to advise you and your dependents of enrollment rights when you are declining health coverage. If you decline enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan as special enrollees, provided you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your dependents or both as special enrollees, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Name a Beneficiary

Beneficiary designations are valid only if they are in writing and signed by the participant. The participant's name should be signed as the name is typed or written on the form. If a married woman is to be named, her full name should be shown. For example: Mary J. Smith, not Mrs. John Smith. Likewise, if the form is to be signed by a married woman, she should sign her given name. If the participant cannot sign his or her name, his or her mark should be witnessed by two persons other than the designated beneficiary(ies).

If you designate several persons as beneficiaries and one dies before you, payment will be made to the others, if any. Primary beneficiaries will share equally unless otherwise stated. When two or more beneficiaries are named and they are not to share equally, indicate the percentage each beneficiary is to receive-do not specify in dollars and cents. For example, 25% to Mary J. Smith, daughter and 75% to John M. Smith, father.

Unless otherwise specified on this form, any sum becoming payable on your death under the plan will be payable as prescribed in such plan. If you don't designate anyone, or if no designated person survives you, payment will be made in the following order: your spouse, your children, your parents, your siblings, your estate.

Avoid naming an estate as beneficiary except when a beneficiary resides in a foreign country. If it is necessary to designate the estate, the expression "Executors or Administrators for the Estate of' should be used.

“If this form provides for a payment to a trustee under a trust agreement, the plan and its agents shall not be obliged to inquire into the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability to the extent of such payment. If a trustee is to be named, show the name and address of the trustee and the date of the trust agreement. For Example: "The ABC Trust Company of Hartford, CT as Trustee under the Trust Agreement dated January 15, 1999."