PREMIERE
HEALTHCARE STAFFING, LLC

Effective Date: _____

- ☐ New Enrollment
- ☐ Rehire Date _____
- ☐ Change of Status Date _____
- ☐ Open Enrollment
- ☐ Other _____

2024 BENEFITS ELECTION FORM

For dependent coverage, you will be required to provide documentation such as: most recent Tax Return, Birth Certificate, Declaration of Registered Domestic Partnership, or Court Documents, depending on circumstances.

SECTION 1 EMPLOYEE ENROLLMENT (Complete in Full)

Employee Name (Last, First, Middle)	Social Security Number (SS#)	Birth Date (mm/dd/yy)	☐ Male ☐ Female
Employee Street Address City State Zip		Home Phone	Work Phone
Emergency Contact: Name Phone No. Relationship			Marital Status
Date of Hire (mm/dd/yy)	Annual Salary	Hours Worked / Pay Period	Employee Type ☐ Full Time ☐ Part Time

Do you use tobacco products? ☐ Yes ☐ No

Coordination of Benefits: Do you or any of your dependents have any other health plan or health insurance (including Medicare) in addition to the Prime Medical Coverage? ☐ Yes ☐ No

If yes, will this coverage remain in effect after the Prime Medical coverage begins? ☐ Yes ☐ No

Name and Group number of other coverage _____

SECTION 2 BENEFIT ELECTIONS

MEDICAL	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
EPO Plan	☐	☐	☐	☐
DENTAL	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Delta Dental PPO Plan	☐	☐	☐	☐
VISION	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
VSP Choice Plan B – Basic	☐	☐	☐	☐
VSP Choice Plan C – Premium	☐	☐	☐	☐

SECTION 3 COVERED INDIVIDUALS (Please print Names, Birthdates and Social Security Numbers)

Name (Last, First, Middle Initial)	Gender	Relationship	Birth Date	SS# (Required)	Primary Care Physician ID#	DeltaCare 12A Provider ID#
SELF	☐ M ☐ F	SELF				
☐ Add ☐ Delete	☐ M ☐ F	☐ SPOUSE ☐ RDP				

Please choose a statement that applies to you:

- ☐ Named spouse or domestic partner is not employed or is self-employed and does not have access to an employer sponsored medical plan.
- ☐ Named spouse or domestic partner is actively employed by your facility.
- ☐ Named spouse or domestic partner is employed and his/her employer offers medical coverage or a contribution toward purchasing medical coverage.
- ☐ Named spouse or domestic partner is employed but his/her employer does not offer medical coverage or a contribution toward purchasing medical coverage.

☐ Add ☐ Delete	☐ M ☐ F	CHILD ☐ Disabled?				
☐ Add ☐ Delete	☐ M ☐ F	CHILD ☐ Disabled?				
☐ Add ☐ Delete	☐ M ☐ F	CHILD ☐ Disabled?				

☐ I decline all health plan coverage for myself, spouse and all dependents

I decline ☐ Medical ☐ Dental ☐ Vision coverage for:
☐ Spouse only ☐ Child(ren) only ☐ Spouse and Child(ren) only

☐ The following Dependents only: _____

☐ I have other medical coverage: Name of Insurance Carrier _____

SECTION 4 LIFE, AD&D, LONG TERM & SHORT TERM DISABILITY* (LTD & STD*) INSURANCE - SUN LIFE FINANCIAL METLIFE LEGAL PLANS / FINANCIAL WELLNESS & IDENTITY PROTECTION - EXPERIAN FLEXIBLE SPENDING ACCOUNT – HR SIMPLIFIED

Coverage Election – Complete the boxes by checking them to indicate your Coverage Elections.

- **All the coverages listed may not be offered under your plan.**
- **Some amounts may be subject to Evidence of Insurability**

Please see the Sun Life highlight sheet for plan details and rates.

MetLife Legal Plan – $7.62 Bi-weekly
Experian – $2.88 Individual /$5.54 Family Bi-weekly
FSA – Medical Savings Account ($3,050 max)
FSA – Dependent Day Care Account ($5,000 max)

*V-STD is only available for employees who reside outside of California.

	Elected	Declined	
Life/AD&D (Full-Time EE's only)	☒	N/A	1X annual salary up to $500,000
Optional EE Life	☐	☐	$_____
Optional Spouse Life	☐	☐	$_____
Optional Child Life	☐	☐	$_____
V-LTD	☐	☐	$_____
V-STD*	☐	☐	$_____
Legal Plan	☐	☐	$_____
Experian	☐	☐	$_____
FSA Medical	☐	☐	$_____ (Annual Election)
FSA Day Care	☐	☐	$_____ (Annual Election)

BENEFICIARY DESIGNATION

Primary Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit
Primary Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit
Contingent Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit
Contingent Beneficiary Name	Relationship	Date of Birth	Social Security Number	% of Benefit

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements. I also certify that the information I provided on this form and at all times during coverage about my family status and my dependents' eligibility for benefits under the benefit plan is accurate. I understand that coverage may be rescinded in the event of fraud or a material misrepresentation, and such rescission is effective on the date of such fraud or misrepresentation.

Fraud Warning: I further understand that any person who knowingly, and with intent to defraud any insurance company, or other person, files an application for insurance or a statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DEDUCTION AUTHORIZATION: I authorize Premiere Healthcare Staffing to take the appropriate payroll deduction on a pre-tax basis from my wages determined by the benefits that I have chosen. If my employment terminates, I authorize my employer to make any required payroll deductions associated with my benefit elections from my final paycheck. I understand that the benefits that I have elected will be in effect January 1 through December 31, 2024 or until a new election is received due to qualifying event or subsequent open enrollment period. **I understand I have 30 days from the qualifying event to notify Human Resources. I also am responsible for notifying Human Resources of dependents that are no longer eligible within 30 days of the qualifying event. Failure to do so may jeopardize my dependent's right to elect COBRA.**

Employee Signature >	Signature of witness (only required if employee signature is "X")	Date	**HR Use Only** Entered: