|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **BENEFITS ENROLLMENT FORM**  **NORAMTEC CONSULTANTS AMERICAS INC.** | | | | | | | |
| **SECTION 1 - EMPLOYEE INFORMATION** | | | | | | | |
| Name (Last, First, MI): | | | | | | | |
| Gender: Male Female | DOB (MM/DD/YY): | | | | SS#: | | |
| Address: | | | | | | | |
| City: State: Zip: | | | | | Daytime Phone: | | |
| Hire Date: / / | | |  | | Eligibility Effective Date: / / | | |
| Email address: | | | | | | | |
| **SECTION 2 - COVERAGE ELECTION OR WAIVER OF COVERAGE** | | | | | | | |
|  | | | | Single | EE+SP or MEC Single+1 | EE+Chil(ren) or MEC Single+2 | Family or MEC Single+3+ |
| **ABA MEC Preventative Care Only Plan (6131)** | | | |  |  |  |  |
| **ABA MEC Limited Medical Benefits Plan (6132)** | | | |  |  |  |  |
| **Excellus SimplyBlue Plus Bronze 4 (HDHP Eligible Plan)** | | | |  |  |  |  |
| **Excellus SimplyBlue Plus Platinum 6** | | | |  |  |  |  |
| **Guardian Dental** | | | |  |  |  |  |
| **Guardian Vision Please Circle 1 Option (VSP or Davis)** | | | |  |  |  |  |
| **COVERAGES DECLINED (circle)** | | | | | | | |
| Medical Dental Vision | | | | | | | |
| I have elected not to apply for coverage at this time for myself or my dependents (if any). I have coverage from: (**circle one**) Medicare Medicaid Spouse Plan Parent Plan Military Plan  List current carrier and ID Number:  I understand that if I waive this coverage and do not have valid coverage in another plan, in accordance with IRS rules, I must pay a fee. The fee is called the individual shared responsibility payment. The fee is sometimes called the "penalty," "Fine," or "individual mandate." ***NOTE: You will not be able to enroll until the next open enrollment unless you experience a Qualifying Event.*** | | | | | | | |
| **SECTION 3 DEPENDENT INFORMATION** | | | | | | | |
| Dependent's Name: (Last, First, MI) | | Gender | Relationship | | Date of Birth | Social Security Number | |
|  | |  |  | |  |  | |
|  | |  |  | |  |  | |
|  | |  |  | |  |  | |
| **SECTION 4 - EMPLOYEE SIGNATURE** | | | | | | | |
| X Date: | | | | | | | |
| I understand I may not drop my coverage unless there is a Qualifying Event (QE) or  the Plan has an Open Enrollment period. Changes must be submitted within 30 days of the Qualifying Event. | | | | | | | |