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| **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 PlanList 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 |
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| **SECTION 4 - EMPLOYEE SIGNATURE** |
| X Date: |
| I understand I may not drop my coverage unless there is a Qualifying Event (QE) orthe Plan has an Open Enrollment period. Changes must be submitted within 30 days of the Qualifying Event. |