INSIGHT

AN EDUCATION SERVICE PARTNER

2019 - 2020 Election and Payroll Deduction Agreement

A. Employee Information – Please Complete

Full Name		Soc. Sec. Number		Date of Birth	
Street Address				Gender ☐ Male ☐ Female	
City/State/Zip					

B. Medical Insurance (Please check one box below) – Please Note: Dollar amounts are based on monthly premiums.

Key Benefits	Employee Only	Employee Spouse	Employee Child(ren)	Employee Family	To confirm 2019/2020 per payroll contribution, enter per payroll amount here:
Key Benefits MEC Plan	☐ $81.46	☐ $130.69	☐ $207.51	☐ $256.63	$_____

☐ **Waive Coverage**

I choose to waive medical benefits through INSIGHT WORKFORCE SOLUTIONS. By waiving coverage I understand that I cannot enroll into INSIGHT WORKFORCE SOLUTIONS' plan until the next open enrollment unless I have a life event change as listed in the IRS Section 125 Plan. I also understand that I have been offered group based insurance coverage that offers me with a medical plan that offers Minimum Value according to the Affordable Care Act. Should I enroll in a medical plan on healthcare.gov and obtain a Federal Subsidy I will do so at my own discretion and risk.

D. Authorization and Signature

I have read the Benefits Plan options explanation. I authorize the elections I have made, as well as contributions for those elections to be made on a pre-tax basis where shown as allowed by the IRS, during the Plan Year. The amount of payroll deduction needed to pay premiums under the insured portions of the Plan will be determined by my employer. This amount will be changed as necessary if the premium charged by the insurance company changes. I understand the above elections are effective throughout the coverage period and may not be changed (including dropping coverage) unless I have a qualifying life even change causing me to need different benefit elections (i.e. marriage, gain or loss of employment, change in residence or worksite, reduction or increase in work hours, divorce/legal separation, unpaid leave, birth, adoption, dependent age limit). I agree to notify my employer within 30 days from the date I incur this change. I understand that all of these regulations are set forth by the IRS and my employer and I cannot change or modify them in any way.

The following is required in certain states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

THIS BENEFIT ELECTION FORM REVOKES ALL OF MY PRIOR BENEFIT ELECTION FROMS AND IS SUBJECT TO THE TERMS AND CONDITIONS SET FORTH IN THIS ENROLLMENT FORM.

EMPLOYEE SIGNATURE: _____ **Date:** _____

KEY BENEFIT ADMINISTRATORS

KEYSOLUTION™

KeySolution Enrollment Form

1. Enrollee Information

Group Name: Insight Workforce Solutions			Plan Coverage Effective Date:	
Last Name:			Date you became a Full time Employee:	
First Name:			Date of Birth (DOB):	
Sex: ☐M ☐F	SS #:		No. Hrs Work/per week:	
Home Phone #:			Work Phone #:	
Street Address:		City:	State:	Zip:

Plan Selection (per your enrollment guide):

MEC Plan ☐

Beneficiary of Life Insurance *(If applicable)*:

Full Name:	Address:	City, State Zip:
Phone #:	Date of Birth:	Relationship:

2. Dependent Information

I would like to be covered under this plan along with the following dependents:

❑Spouse ❑Domestic Partner	Last Name:	First:	SS#:	DOB:	❑Male ❑Female
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disable[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					
Last Name:		First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]					

[1] For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.

[2] If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for benefit plan participation for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

☐ **I am waiving/declining coverage for myself and my dependents**

Employee (print name)**:** ______________________________

Employee Signature:____Date:_______________