MMS CROWLEY

ENROLLMENT FORM

PERSONAL INFORMATION

1. Name (Last, First, M.I.)			2. Social Security Number _____-_____-_____
3. Address (Number, Street, City, State, ZIP Code)			4. Phone No. ( ) -
5. Gender ☐ Male ☐ Female	6. Date of Birth (MM/DD/YY) / /	7. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	8. Date of Hire (MM/DD/YY) / /
9. Email Address	10. Hours Worked	11. Job Title	

FAMILY INFORMATION Complete for each covered dependent

Relationship	Full Name *(Specify last name if different from yours)*	Date of Birth	Gender	Social Security Number
Spouse		_____/____/_____	■ Male ☐ Female	_____-_____-_____
Child		_____/____/_____	☐ Male ☐ Female	_____-_____-_____
Child		_____/____/_____	☐ Male ☐ Female	_____-_____-_____
Child		_____/____/_____	☐ Male ☐ Female	_____-_____-_____
Child		_____/____/_____	☐ Male ☐ Female	_____-_____-_____
Child		_____/____/_____	☐ Male ☐ Female	_____-_____-_____
Child		_____/____/_____	☐ Male ☐ Female	_____-_____-_____

Please complete for yourself and each covered dependent:

- Do any of the above have other health insurance? ☐ Yes ■ No
  If yes, please list names and carrier information _____
- Are any of the above dependents (spouse and/or children) totally disabled? ☐ Yes ☐ No
  If yes, please list names _____
  Dependents – If totally disabled prior to age 26, attach proof of disability for eligibility review.

PLAN SELECTION

Cigna Medical OAP

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☒ Waive/decline medical coverage

Waive Reason (please check 1 circle):

- ○ Covered by Spouse's Plan
- ○ Covered by Parent's Plan
- ◉ Coverage with Medicare or TriCare
- ○ No other coverage

Cigna Dental DPPO

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Waive/decline dental coverage

Cigna Vision

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Waive/decline vision coverage

LIFE INSURANCE BENEFICIARY DESIGNATION
PLEASE LIST THE INDIVIDUALS THAT WILL RECEIVE YOUR LIFE INSURANCE BENEFIT

Name	Phone Number	Relationship	Percentage	Primary (P) or Secondary (S)

Authorization

As an eligible employee of these plans, I acknowledge that I have received a Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the plan.

In accordance with my rights under the Plan, I elect the benefits indicated and designate the necessary amounts for each benefit I have selected for the plan year specified below. The employer and I agree that my cash compensation will be redirected by the amounts set forth above for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

I understand that my elections are for the plan year commencing January 1st, 2025 and that my elections may be changed only during open enrollment each year.

Information regarding Special Enrollment Periods:

If you are declining enrollment 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, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have any new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Other Terms and Conditions:

I understand that:

I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full time to part time or from part time to full time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, or such other events as the Plan Administrator determined will permit a change or revocation of an election).

The plan Administrator may redirect or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The redirection in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefits programs maintained by my Employer.

If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will not be eligible to elect Optional or Contributory coverage plans until the next annual open enrollment period, or qualifying event. You may be subject to waiting periods or reduced benefits if you decide to enroll at a later date. In addition, this compensation redirection agreement will continue by its terms in the amount of the required contribution for the benefit options elected.

Notice:

A person is guilty of insurance fraud if he or she submits an application or files a claim containing a false or deceptive statement, with intent to defraud, (or knowing that he or she is aiding a fraud against an insurance company).

X_____

Employee Signature **Date**