FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA EMPLOYEE BENEFITS
A nonprofit benefit Plan exclusively serving YMCAs since 1970.

FORM: NEW ENROLLMENTS OR CHANGES

Use this form for new hires or to provide changes for existing employees.

Instructions: The fields in this form must be filled out digitally by the employee electing or waiving benefits. The portion on the bottom of the last page needs to be completed by the person responsible for administering benefits at your YMCA.

PLEASE SELECT TYPE: ◯ **New Hire** ◯ **Open Enrollment** ◯ **Change** ◯ **COBRA**

For Changes

Type of Qualifying Life Event (QLE): _____ **Date of QLE:** _____
(i.e. Marriage, Divorce, Birth/Adoption of Child, Death)

Are there any additional details about the life event we should be aware of?

EMPLOYEE INFO

First & Last Name: _____ **Gender:** ◯ Male ◯ Female

Social Security Number: _____ **Date of Birth:** _____
(MM/DD/YYYY)

Employee's Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** _____

*If making a change to what is currently in our system **ONLY** enter what is changing*

BENEFITS

Only complete the fields below for benefits that your YMCA offers with YMCA Employee Benefits. All YEB medical plans include coverage for Vision with EyeMed, as well as our Employee Assistance Program & WorkLife Services with UnitedHealthcare.

Medical

Check here if your Y doesn't offer this plan type: _____

Check one: I want coverage ◯ Decline Coverage ◯ *If declining, why?* _____

Name of Medical Plan enrolling in: _____

Coverage Type (check one):
◯ Employee Only ◯ Employee + Spouse
◯ Employee + Child(ren) ◯ Employee + Family

Dental

Check here if your Y doesn't offer this plan type: ☐

Check one: I want coverage ◯ Decline Coverage ◯ *If declining, why?* _____

Coverage Type (check one):

◯ Employee Only ◯ Employee + Spouse
◯ Employee + Child(ren) ◯ Employee + Family

Other Benefits

Check here if your Y doesn't offer any of these: ☐

Check the benefits below you wish to enroll in (if offered by your YMCA). If your YMCA contributes 100% of the premium to any of the plans below, you'll be enrolled automatically.

☐ **Basic Life & AD&D** ☐ **Optional Life** ☐ **Dependent Life** ☐ **Long-Term Disability**

Are you a Tobacco User? ◯ Yes ◯ No

DEPENDENT(S)

Enter information below for dependents you wish to enroll under your Medical and/or Dental plan.

Please Note: All dependents enrolled for the first time on a YMCA Employee Benefits medical plan will be required to verify eligibility within the first 60 days of enrollment. After enrollment, employees with new dependents covered will receive instructions in the mail.

Dependent #1

Enroll this dependent in: Medical ☐ Dental ☐

First & Last Name: _____ **Gender:** ◯ Male ◯ Female

Social Security Number: _____ **Date of Birth:** _____

Relationship Type: Spouse/Domestic Partner* ◯ Child ◯ **Check if disabled:** ☐

Dependent #2

Enroll this dependent in: Medical ☐ Dental ☐

First & Last Name: _____ **Gender:** ◯ Male ◯ Female

Social Security Number: _____ **Date of Birth:** _____

Relationship Type: Spouse/Domestic Partner* ◯ Child ◯ **Check if disabled:** ☐

Dependent #3

Enroll this dependent in: Medical ☐ Dental ☐

First & Last Name: _____ **Gender:** ◯ Male ◯ Female

Social Security Number: _____ **Date of Birth:** _____

Relationship Type: Spouse/Domestic Partner* ◯ Child ◯ **Check if disabled:** ☐

Dependent #4

Enroll this dependent in: Medical ☐ Dental ☐

First & Last Name: _____ **Gender:** ○ Male ○ Female

Social Security Number: _____ **Date of Birth:** _____

Relationship Type: Spouse/Domestic Partner* ○ Child ○ **Check if disabled:** ☐

Dependent #5

Enroll this dependent in: Medical ☐ Dental ☐

First & Last Name: _____ **Gender:** ○ Male ○ Female

Social Security Number: _____ **Date of Birth:** _____

Relationship Type: Spouse/Domestic Partner* ○ Child ○ **Check if disabled:** ☐

For additional dependents, please include the information above for each additional dependent on a separate page and submit together.

**Eligibility for Domestic Partners varies by YMCA*

BENEFICIARY DESIGNATION/CHANGE

If more than one beneficiary is designated, settlement will be made in equal shares to each of the beneficiaries that survive the insured, unless otherwise provided therein. If no designated beneficiary survives the insured, settlement will be made to the estate of the insured, unless otherwise provided in the group policy.

Percentages should total 100%.

Beneficiary #1

First & Last Name: _____ **Relationship:** _____

Beneficiary Change Effective Date: _____ **Date of Birth:** _____

Percentage: _____ % **Primary or Contingent:** **Which Plan:** ☐ Basic ☐ Optional

Beneficiary #2

First & Last Name: _____ **Relationship:** _____

Beneficiary Change Effective Date: _____ **Date of Birth:** _____

Percentage: _____ % **Primary or Contingent:** **Which Plan:** ☐ Basic ☐ Optional

Beneficiary #3

First & Last Name: _____ **Relationship:** _____

Beneficiary Change Effective Date: _____ **Date of Birth:** _____

Percentage: _____ % **Primary or Contingent:** **Which Plan:** ☐ Basic ☐ Optional

Complete beneficiary information only if applicable; if more than 3 are needed, please attach to this form.

EMPLOYEE SIGNATURE

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give the YMCA's Administrator and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us, the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Plan Administrator, after it has been approved by the Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay.

NOTICE of Enrollment Rights

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the Plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this Plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after such marriage, birth, adoption, or placement for adoption.

Signature: _____ **Date:** _____

Once all information has been completed digitally, please print, then sign above and submit to your YMCA.

YMCA ADMINISTRATOR

The information below to be completed by YMCA before submitting.

YMCA's 4-digit Association #: _____ **Today's Date:** _____

Annual Salary: _____ **Date of Hire:** _____

Administrator's Name: _____

Admin Signature: _____ **Date:** _____

Administrators: *If your YMCA has edit-access in Benefitsolver, please enter the information above directly and retain this original form on file at your YMCA. If you do not have edit-acces, please submit the completed and approved form to YMCA Employee Benefits for processing by uploading it to your YMCA's secure folder in the Benefitsolver Document Center. For instructions, see the Benefitsolver Administrator Training Guide.*

Administrators, if you have any additional information that YMCA Employee Benefits staff should be aware of in relation to this form, please include it in the space below: