

OPEN ENROLLMENT 2020

Attached you will find all the forms necessary to change or enroll in Medical, Dental, Vision and Voluntary Unum Benefits.

ALL FULL TIME STAFF: Please complete and return all the relevant medical, dental, and vision documents via email to benefits@woodfords.org by the final deadline of August 10, 2020.

UNUM Voluntary Benefits Open Enrollment only from July 29th – August 5th for FT and PT Staff.

TO DO LIST:

- BENEFIT ELECTION FORM ANNUAL OPEN ENROLLMENT – **Mandatory**
- PRE – TAX BENEFIT ELECTION AGREEMENT – **Mandatory if electing medical, dental and/or vision**
- MY HEALTH MATH APPOINTMENT – **Recommended**
- HARVARD PILGRIM HEALTHCARE WAIVER FORM – **Mandatory if declining coverage**
- HARVARD PILGRIM MEDICAL ENROLLMENT FORM – **For changes in coverage only**
- ANTHEM DENTAL ENROLLMENT/DECLINATION FORM - **For changes in coverage only**
- VSP VISION ENROLLMENT FORM - **For changes in coverage only**
- UNUM LIFE INSURANCE BENEFICIARY FORM – **Mandatory for updates only**
- UNUM SUPPLEMENTAL INSURANCE COVERAGE FORM – **Optional for upgrade in Life and AD&D for FT and PT staff**

Please return your Annual Benefit Election Forms to HR by August 3rd Early Bird Deadline to be eligible to win Hannaford Gift Cards.

Final Deadline for Open Enrollment: August 10, 2020.

PLEASE NOTE the new email address for benefits enrollment:

- Send all forms to benefits@woodfords.org

Thank you,
Karen Murphy, Benefits Specialist



Benefit Election Form – Annual Open Enrollment

For the period September 1, 2020 through August 31, 2021

All Full-Time Staff: Please fill out, sign & return this annual Benefit Election Form to HR by or before Aug 10, 2020 deadline.

Return to HR via email/scan to HR at benefits@woodfords.org or by HR Confidential FAX # 207-835-4862. Thank you!

Name (Please Print): _____

Employee ID: _____

MEDICAL PLAN OPTION #1 Harvard Pilgrim HMO		MEDICAL PLAN Option #2 Harvard Pilgrim POS/HSA - \$3,000 H.S.A 1		MEDICAL PLAN Option #3 Harvard Pilgrim POS/HSA - \$5,000 H.S.A 2		DENTAL PLAN Anthem		VISION PLAN VSP	
Per Payroll		Per Payroll		Per Payroll		Per Payroll		Per Payroll	
Employee Only HMO-EM <input type="checkbox"/>	\$38.27	Employee Only P576-E <input type="checkbox"/>	\$16.50	Employee Only HSA2 <input type="checkbox"/>	\$10.00	Employee Only 6123 <input type="checkbox"/>	\$3.24	Employee Only <input type="checkbox"/>	\$1.57
		Funds added to HSA Account	\$40.00	Funds added to HSA Account	\$62.50				
Employee and Spouse HMO-3576-S <input type="checkbox"/>	\$274.01	Employee and Spouse HSA H576-S <input type="checkbox"/>	\$219.53	Employee and Spouse HSA-P576-S <input type="checkbox"/>	\$134.02	Employee + 1 6123-2 <input type="checkbox"/>	\$20.86	Employee + 1 <input type="checkbox"/>	\$2.52
		Funds added to HSA Account	\$40.00	Funds added to HSA Account	\$62.50				
Employee and Child(ren) HMO - 3576-C <input type="checkbox"/>	\$232.48	Employee and Child(ren) HSA-H576-C <input type="checkbox"/>	\$130.77	Employee and Child(ren) HSA-P576-C <input type="checkbox"/>	\$75.22	Employee + 2 or more 6123-3 <input type="checkbox"/>	\$48.28	Employee + Children <input type="checkbox"/>	\$2.57
		Funds added to HSA Account	\$40.00	Funds added to HSA Account	\$62.50				
Employee and Family HMO - 3576-F <input type="checkbox"/>	\$493.29	Employee and Family HSA-H576-F <input type="checkbox"/>	\$341.99	Employee and Family HSA-P576-F <input type="checkbox"/>	\$215.64			Employee and Family <input type="checkbox"/>	\$4.14

Additional bi-weekly personal contributions to my H.S.A account through payroll deductions

I am participating in the H.S.A plan and wish to have the additional contribution of \$_____ dollars deducted each pay period and deposited into my H.S.A account. I can modify my H.S.A deduction, throughout my coverage, by submitting a written, dated, and signed request to the Human Resources Department.

DECLINE: I am declining offered MEDICAL coverage through Woodfords Family Services. *Annually at Open Enrollment, eligible employees who prefer to waive or "opt out" of any of the medical plans, must provide timely proof of their enrollment in another eligible medical plan. Woodfords will provide a benefit stipend that is equivalent to an additional \$20 each paycheck for eligible employees once this proof of other enrollment has been delivered to HR.*

DECLINE: I decline DENTAL coverage through Woodfords

DECLINE: I decline VISION coverage through Woodfords

My annual Open Enrollment Election is as follows:

I am not making any changes. I am keeping all of my benefit elections the same as they were for the 2019-2020 benefit year.

I am making changes to my benefit elections. My new benefit elections are indicated above. I have attached required, updated Enrollment Forms.

Annual Health Benefit Plan Selection Notice

The elections made on this form represent my choices in benefit elections for the plan year September 1, 2020 - August 31, 2021. Any changes in employment and/or a qualifying event may affect my coverage and should be discussed with a representative of the Human Resources Department.

Signature

Date

Pre-Tax Benefit Election Agreement for Woodfords Family Services

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state income taxes.

Once you have made your election, you may not change your election unless you experience a change in status. Please note for purposes of this Agreement, the term "spouse" denotes an IRS-defined spouse. You may be able to change your benefit election when:

- You experience a change in your IRS defined legal marital status;
- A child is born to you or you adopt a child; or your spouse or qualified dependent dies; Your spouse either gets a job or loses a job;
- You or your spouse take or return from an unpaid leave of absence, a strike or lockout;
- Your health insurance cost or coverage changes significantly because of your spouse's employment;
- A change in your or your spouse's work status (such as changing from part-time to full-time);
- You or your spouse's worksite changes which impacts your eligibility (such as moving out of an HMO service area);
- You, your spouse or qualified dependent gain or lose eligibility;
- You or your spouse's plan either adds or eliminates a benefit option;
- You, your spouse or qualified dependent becomes entitled to Medicare or Medicaid
- A reduction in hours below 30 hours of service per week without loss of eligibility for major medical coverage;
- In order to enroll in a Qualified Health Plan through a "Marketplace" during the Marketplace's annual open enrollment period.

Note: To be permitted, any change in election must be consistent with the status event that has occurred.

HSA (Health Savings Account) Exception to the above: IRS Notice 2004(50) exempts HSA contributions from these rules. An employee who elects to make HSA contributions under a cafeteria plan may start or stop the election (or increase or decrease the election) at any time, so long as the change is prospective.

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits listed below. I understand this agreement will remain in effect until the end of the plan year unless one of the events listed above occurs, in which case I may revoke or change this agreement as provided in the Summary Plan Description. I further understand that in the event the cost of a benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

The plans covered by this agreement are: Health, Dental and Vision Insurance, Health Savings Accounts.

I understand the above agreement.

Employee Name (please print)

Social Security Number

Address

City

State

Zip

Employee Signature

Date

IRS regulations prohibit sole proprietors, partners, LLC members and greater than 2% subchapter S Corp. owners from participating in a flexible benefit plan.

The first 100 employees receive a \$15 Amazon.com Gift Card*



Selecting the right health plan is hard. MyHealthMath is here to help.

Engage with MyHealthMath to better understand your health insurance options and choose the health plan that's right for you and your family.

1. Schedule a 15-minute phone call.

- At the time of your appointment, MyHealthMath will call you.

2. Be ready to answer some questions about medical usage for you and your family**.

For example:

- How many doctors' visits might you have?
- Do you receive other services (like physical therapy)?
- What are the names and dosages of your prescriptions?

3. 2-3 business days later, check your email for a personalized report.

- Using your medical information, MyHealthMath generates a report that is 100% unique to you. Your report will outline the Woodfords Family Services health plans in order of potential savings.

Get Started Here:
myhealthmath.com/woodfords



Or scan this code



Need help answering medical information about your family members? Invite a trusted family member to engage with you!

*The first 100 employees who complete a phone call with MyHealthMath between 7/22-8/5/2020 will receive a \$15 Amazon.com Gift Card! Gift cards will be emailed no later than August 24, 2020. The gift card will be delivered to the same email address used to send the MyHealthMath report, and will come from gc-orders@gc.email.amazon.com.

** The information you share with MyHealthMath is completely confidential, and your personal information is never shared. MyHealthMath uses aggregated, de-identified information in its analytics. No personal financial information or SSN are required to participate.

MyHealthMath[®]



ME Health Care Coverage Waiver Form

Employer Company Name: _____

Employee Name: _____

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in Harvard Pilgrim Health Care health insurance offered at this time by or through my employer for the following reason:

- I am covered under another group plan as a spouse or dependent
- I am covered by Medicare or Veterans Program
- I have purchased subsidized coverage through state or federal Exchange
- I am covered under another group plan sponsored by a second employer

For each person declining to enroll in Harvard Pilgrim at this time because of other health care coverage listed above, please provide the following information:

Subscriber Name: _____

Carrier Name: _____ Group/Policy Number: _____

- I am covered under another carrier’s plan sponsored by this employer
- I am covered through an Individual plan, or purchased coverage through state or federal Exchange with no subsidy
- I do not wish to participate in health care benefits at this time (I am declining health insurance entirely)

Notice of Enrollment Rights

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 health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a 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.

I understand that any person choosing to enroll later must meet Harvard Pilgrim’s requirements for eligibility and for late enrollees.

Employee Signature: _____ Date: _____

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that Harvard Pilgrim has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Employer Signature: _____ Date: _____



REASONS FOR SUBMISSION (PLEASE CHECK ONE) <input type="checkbox"/> NEW ENROLLMENT/CONTRACT <input type="checkbox"/> CHANGE TO CONTRACT <input type="checkbox"/> TERMINATE CONTRACT	QUALIFYING EVENT DATE: _____ <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> COBRA <input type="checkbox"/> LOSS OF INSURANCE <input type="checkbox"/> COURT ORDER <input type="checkbox"/> BIRTH/ADOPTION <input type="checkbox"/> P/T TO F/T <input type="checkbox"/> MARRIAGE/DIVORCE <input type="checkbox"/> MOVED IN/OUT OF SERVICE AREA <input type="checkbox"/> DEATH <input type="checkbox"/> VOLUNTARY CANCELLATION
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REASON FOR CHANGES (CHECK ALL THAT APPLY)
 CHANGE COVERAGE TYPE ADD DEPENDENT LISTED TERMINATE DEPENDENT LISTED TRANSFER/RE-ENROLL TO COBRA
 OTHER: _____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	GROUP #DIVISION	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE
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SUBSCRIBER INFORMATION

HP ID	PRODUCT: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> ACCESS AMERICA	PLAN NAME			
SUBSCRIBER FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
SSN	HOME PHONE	WORK PHONE	CELL PHONE	EMAIL	
STREET ADDRESS (NO PO BOX)		APT #	CITY	STATE	ZIP
PRIMARY LANGUAGE (OPTIONAL)	PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #	

SPOUSE INFORMATION

SPOUSE FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
SSN	MAILING ADDRESS (IF DIFFERENT)			RELATION CODE
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID #	

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATION CODE
MAILING ADDRESS (IF DIFFERENT)				SSN	
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID#		

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATION CODE
MAILING ADDRESS (IF DIFFERENT)				SSN	
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID#		

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATION CODE
MAILING ADDRESS (IF DIFFERENT)				SSN	
PCP FULL NAME	PCP TOWN	CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP ID#		

PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? YES. PLEASE COMPLETE NO

NAME OF HEALTH PLAN	HEALTH PLAN ID NUMBER	EFFECTIVE DATE	NAMES OF SUBSCRIBER
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MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINISTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

EMPLOYEE SIGNATURE _____ DATE _____ EMPLOYER SIGNATURE _____ DATE _____
 NH_7458_0718

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	Contract change	Termination
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- ❖ **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- ❖ **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. **IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.**
- ❖ **Primary Care Provider:** If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- ❖ **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
 - 02 Spouse/Civil Union
 - 03 Child up to age 26
 - 06 Disabled (verification required)
 - 07 Ex-spouse
 - DP Domestic Partner
 - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.



Dental Membership Enrollment Form

Anthem
 Dental Enrollment Department
 PO Box 1193
 Minneapolis MN 55440-1193

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru D and return form to benefit administrator.

Employee's Name:			Last First Middle Initial			Social Security Number		
						/ /		
Gender:		Marital Status:		Date of Birth (Month-Day-Year)				
Male <input type="checkbox"/> Female <input type="checkbox"/>		Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/>		/ /				
Employee's Address:			Address			Home Phone Number		Work Phone Number
			City			State		Zip Code

PART B – ENROLLMENT INFORMATION - Select Coverage Type (Check One Box Only):

<input type="checkbox"/> Employee Only*	<input type="checkbox"/> Family
<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> No Coverage * If waiving coverage for employee and/or any eligible family members, you must complete Part D.
<input type="checkbox"/> Employee and Dependent Child(ren)	

PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name	Gender		Date of Birth Month/Day/Year		Full Time Student?		Unmarried?	
		M	F	/	/	Y	N	Y	N
Spouse				/	/				
Dependent Child		M	F	/	/	Y	N	Y	N
Dependent Child		M	F	/	/	Y	N	Y	N
Dependent Child		M	F	/	/	Y	N	Y	N

PART D – EMPLOYEE SIGNATURE – Select One

Do you (the employee) have other dental coverage? Yes No Do your dependents have other dental coverage? Yes No Name of Carrier: _____ Policy/Identification Number: _____

I **waive** coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes. **Employee Signature:** _____ **Date:** _____

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**
Employee Signature: _____ **Date:** _____

PART E – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Group Hire Date: _____ Prior Coverage Start Date (if applicable): _____ Coverage Effective Date: _____	<input type="checkbox"/> Rehire Date Lay Off Began: _____ Date Rehired: _____
<input type="checkbox"/> Existing Anthem Dental Group Hire Date: _____ Prior Coverage Start Date (if applicable): _____ Coverage Effective Date: _____	<input type="checkbox"/> Return from Leave of Absence Date Leave Began: _____ / _____ / _____ Date Returned to Work: _____ / _____ / _____
<input type="checkbox"/> Open Enrollment Effective Date: _____	<input type="checkbox"/> Employee Change Part Time to Full Time Date of Status Change: _____ Effective Date: _____
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine effective date. Hire Date: _____ Effective Date: _____	<input type="checkbox"/> Previously Waived Coverage or Loss of Coverage Qualifying Event Reason: _____ Hire Date: _____ Event Date: _____ Effective Date: _____ / _____ / _____
Group Name: _____	
Group Representative's Signature: _____	
Group & Subgroup Numbers: _____	
Date: _____ Phone Number: _____	



VISION BENEFIT Enrollment Form

Reason for Enrollment Form Submission:

_____ Annual Open Enrollment: **Effective Date 9/1/2019**

OR: _____ New Employee, *Enrollment Eff When Benefit Eligible (confirm w/HR)*

Name of group (employer): _____ **Woodfords Family Services**

Employee last name, first name, middle initial: _____

Social Security Number: _____ - _____ - _____

Gender: Male Female

Date of birth (month/date/year): _____

- Type of coverage selected:
- Employee only
 - Employee and Spouse
 - Employee and Child(ren)
 - Employee and Family
 - Decline / waive coverage

IF ENROLLING ELIGIBLE DEPENDENTS, PLEASE FILL OUT BELOW, FOR DEPENDENTS YOU WISH TO ENROLL:

PLEASE PRINT:

*** Dependent Relationship:** S=spouse, C=child, H=Handicapped child, T= Student

Dependent Last name	Dependent First name	Gender	* Dependent Relationship	Date of birth mm/dd/yyyy
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /

Employee Signature: _____ Date: _____

Please Print Name: _____

Valuable insurance available from your employer

Your enrollment is from **July 29 - Aug 5.**

To enroll, call **(877) 700-8136.**

The line will be open Mon - Fri, 8AM-8PM EST.

Your employer is offering coverage from Unum, a leading provider of employee benefits.

Don't miss your opportunity to apply for these valuable benefits!

It can be difficult to budget for life's unexpected emergencies.

That's why Woodfords Family Services is giving you the opportunity to purchase this important coverage from Unum. It can help protect your finances from a variety of common situations — and can give you the assurance that you've made a smart decision for yourself and your family.



Group Term Life Insurance

Term Life Insurance provides money to your family if you die within a certain time period, or "term." It can help them with final arrangements, living expenses, tuition and more. It could also include an Accidental Death & Dismemberment benefit — which provides an additional amount if you die in an accident, or if you survive but have severe injuries like the loss of a limb.



Critical Illness Insurance*

Critical Illness Insurance can pay money directly to you if you're diagnosed with a covered serious health condition. You can use the lump-sum payment to help with co-pays and deductibles — or any of your other expenses. Your children are automatically covered and your spouse can also get coverage. A benefit for qualified health screening tests is also included.



Group Accident Insurance*

Accident Insurance can pay money directly to you if you get hurt and need medical attention. The amount is based on your specific injury and treatment. It covers things like ER treatment, fractures, stitches and more. You can use the money however you choose.



Individual Whole Life Insurance

Whole Life Insurance provides money to your family if you die, to help them with ongoing expenses. This coverage lasts your whole life; it doesn't end after a certain time period. The rates stay the same as long as you have coverage. Whole Life also builds cash value. You can borrow from it, or use it to pay off your coverage early. You can even request a "living benefit," or early payout, if you're diagnosed with a terminal illness that limits your life expectancy to a year or less.



Individual Short Term Disability Insurance

Short Term Disability Insurance replaces part of your monthly income if you can't work because of a covered injury, illness or childbirth. How long you can receive benefits will depend on your plan and how long you're disabled.

*** LIMITED BENEFIT POLICY.**

Group products are underwritten by: Unum Life Insurance Company of America, Portland, Maine and Unum Insurance Company, Portland, Maine

Individual products are underwritten by: Provident Life and Accident Insurance Company, Chattanooga, Tennessee

These policies or their provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.

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unum.com



**BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH
& DISMEMBERMENT INSURANCE**

Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI) _____	Social Security Number _____
Date of Birth: _____	

Employer Name Woodfords Family Services	Check the coverages listed below to which this beneficiary designation applies: <input checked="" type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input checked="" type="checkbox"/> AD&D <input type="checkbox"/> All
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SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If all primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X _____
Employee Signature Date

Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).
- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).
- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.
- **Trust** – You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.
- **Supplemental Life** is life insurance elected by you for which you pay the premiums.
- **AD&D** is Accidental Death & Dismemberment coverage.
- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.
- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

Beneficiary Information

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition. Disabled children over the maximum child age may be eligible for benefits, please see your plan administrator for more details.

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

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