CONFIDENTIAL

2025
Open Enrollment Form

SECTION 1 - No Enrollment Changes

☐ **I do NOT want to make any changes to my current medical election.**
(Please check the box, then go to Section 5 you do not need to complete section 2, 3 and 4).

☐ **I am declining coverage and do not want to enroll myself on the medical plan.**
(Please check the box, then go to Section 5 you do not need to complete section 2, 3 and 4).

SECTION 2 - Employee Information (Only complete if you are making changes).

Name (Last, First MI) _____ Date of Birth _____ Gender _____

Social Security Number _____ Date of Hire _____ Email Address _____

Address _____ Home Phone Number _____

City _____ State _____ Zip Code _____

SECTION 3 - Open Enrollment Elections (Only complete if you are making changes).

Plan	Carrier	Plan Election	Benefit Election
Medical, Rx	United Healthcare	☐ $5,000 Deductible HSA Plan	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ***For dependent coverage, complete Section 4 for all eligible family members***

SECTION 4 - Enrollment (Only complete if you are making changes).

I elect to enroll myself and my dependents listed below. Dependent shall mean any of the following: (a) The employee's legal spouse; or (b) Eligible employee's natural or adopted child(ren) including child(ren) placed with the employee for the purpose of adoption, or step child(ren), living in a parent-child relationship with the employee, who resides in the same country as the covered employee, and is under 26 years of age.

☐ Medical

Name	SSN	Relationship	Gender	Date of Birth	3 Digit Medical Group # (HMO Only)

SECTION 5 - Acknowledgement and Authorization

1. If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan, provided that you request enrollment within 31 days after your coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

2. I agree that my enrolled family and I shall abide by the provision of coverage in the Service Agreement of the Plan under which we are enrolled. The Plan document will determine the rights and responsibilities of member(s) and will govern in the event of a conflict with any benefits comparison or Summary Plan Description.

3. I hereby authorize any provider, insurance company, or organization to release any information regarding treatment or benefits payable, including disability or employment-related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining the benefits payable in connection with these Plans.

4. If I elect to enroll in any of the insurance plans offered by Team Management, I authorize the deduction from my earnings of the required premiums.

5. I certify that the information provided on this form is true and correct.

Employee's Printed Name	Employee's Signature	Date

Please return this form to:

Susan Kissinger

susankissinger@teammanagement.net