GROUP INSURANCE ENROLLMENT/CHANGE FORM 2015

CAROLINABANK
Building on tradition since 1936

EMPLOYEE INFORMATION: ***Effective Date:***

Name:		SSN:
Address:		
Telephone:	Marital status:	DOB:

Benefit Plan	**Bi-Weekly Cost**				
	Single	**Employee/Spouse**	**Emp/Child (1 Child)**	**Family**	**Decline**
Medical- HRA Plan	☐ $37.59	☐ $259.59	☐ $259.59	☐ $401.28	☐ Decline
Medical- PPO Plan	☐ $46.82	☐ $284.51	☐ $284.51	☐ $431.28	☐ Decline
Dental- Delta	☐ $0.00	☐ $15.51	☐ $20.69	☐ $41.49	☐ Decline
Vision- PEP	☐ $3.92	☐ $7.75	☐ $6.60	☐ $11.08	☐ Decline
Additional Life Ins Maximum of $500,000. Guarantee issue amount of $100,000 in increments of $1,000.	☐ 10k ☐ 20k ☐ 30k ☐ 40k ☐ 50k ☐ 60k ☐ 70k ☐ 80k ☐ 90k ☐ 100k			Other	☐ Decline
Spouse Additional Life available in increments of $5000 guarantee issue amount, $25,000.	☐ $10k	☐ $15k	☐ $20k	☐ $25k	Other ☐ Decline
Dependent Additional Life Ins.(rate is for all children)	☐ $2,500		☐ $5,000	☐ $10,000	☐ Decline

MY BENEFIT ELECTION IS (CHECK √ YOUR CHOICE(S) :

If you would like to keep your benefit elections the same for the 2014/2015 plan year then check this box:☐

Flex Benefit Elections	
I wish to participate in this account for 2014	☐ Flex Spending ☐ Dependent Care
Medical/Dental/Vision Spending Election (maximum election $2550)	Annual Election: $
Dependent Care Election (IRS maximum allowable election $2500 single, $5000 family)	Election Amount: $

Please provide covered dependent information for any dependent elections above on back of this form.

AGREEMENT FOR MEDICAL AND/OR DENTAL AND/OR LIFE INSURANCE COVERAGE:

My signature below indicates that I have chosen voluntarily the type of coverage that I believe is most appropriate for my eligible dependents and me. I understand that the company does not recommend, endorse or guarantee the quality of care or service that is provided. I understand that my enrollment selection will become effective on the Effective Date shown above. I also understand that I have the option to change plans only once each year during the annual open enrollment, which will be held in December 2015. I hereby authorize the company, to deduct from my pay the amount determined. To apply towards the monthly premium for my choice of coverage's elected above. I hereby certify the above information is correct.

_____ _____

EMPLOYEE SIGNATURE DATE SIGNED

Dependent must be recorded on reverse side

Request For Change Section

ENROLLMENT CHANGE REQUESTED:

_____**Add Dependent** _____**Drop Dependent** _____Add Employee Coverage _____Drop Employee Coverage

Reason for Change (Qualifying Event):

_____ Marriage _____ Birth/Adoption _____Termination

_____ Divorce _____ Death _____ Other

Medical Covered Dependents: Please list below the dependent you are adding or dropping.

Name	Relationship	Sex	Birth Date	College Student?	SSN #

Dental Covered Dependents: Please list below the dependents you are adding or dropping

Name	Relationship	Sex	Birth Date	College Student?	SSN #

Vision Covered Dependents: Please list below the dependents your are adding or dropping

Name	Relationship	Sex	Birth Date	College Student?	SSN #

LIFE INSURANCE BENEFICIARY

Primary

Name:	Relationship:	SSN:	Percentage:
Name:	Relationship:	SSN:	Percentage:

Contingent

Name:	Relationship:	SSN:	Percentage:
Name:	Relationship:	SSN:	Percentage: