GROUP INSURANCE ENROLLMENT/CHANGE FORM 2018

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/Children**	**Family**	**Decline**
Medical- HDHP	☐ $6.00	☐ $219.23	☐ $152.31	☐ $343.85	☐ Decline
Medical- Silver Plan	☐ $30.92	☐ $268.15	☐ $193.38	☐ $406.15	☐ Decline
Medical- Gold Plan	☐ $55.85	☐ $317.08	☐ $234.46	☐ $468.92	☐ Decline
Dental- Delta	☐ $0.00	☐ $15.91	☐ $21.22	☐ $42.56	☐ 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	
Dependent Basic Life Insurance	☐ $5,000				☐ Decline							
Short-Term Disability**	☐ Yes				☐ No							
Long-Term Disability**	☐ Yes				☐ No							

****Please refer to the formula in your Benefit Enrollment Guide for your Disability & Life costs.****

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

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 2018. 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: