AMWINS CONNECT ADMINISTRATORS
11350 McCormick Road
Suite 400 Executive Plaza 4
Hunt Valley, MD 21031
PHONE: 410-832-1300 OR 800-638-6085
FAX: 410-832-1316

EMPLOYEE ELECTION FORM

(This is not an application for insurance)

EMPLOYER: _____ **EFFECTIVE DATE:** _____ ☐ **COBRA/State Enrollee**

ACCOUNT #: _____ ☐ **New Employee** ☐ **Addition of Dependent(s)** ☐ **Coverage Change**

☐ **Open Enrollment** ☐ **Demographic Updates** ☐ **Waiver of Coverage**

Employee Demographic Information

LAST NAME _____ FIRST NAME _____ MI ____ SSN _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX ☐ M ☐ F DATE OF BIRTH _____ PHONE _____ EMAIL _____

MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ DOM PARTNER DATE OF MARRIAGE _____ DATE OF HIRE _____

HOURS PER WEEK _____ ANNUAL SALARY_____ BENEFIT CLASS _____

OCCUPATION _____ COST CENTER _____

Coverage Level – Make selections for employee and all covered dependents. Blank boxes indicate no election.

	NAME	DOB	SSN	SEX M/F	MED	DEN	VIS	MEDICAL PCP #	CURR PATIENT Y/N	DENTAL #	DEBIT CARD Y/N
EE					☐	☐	☐				
SP/DP					☐	☐	☐				
DEP					☐	☐	☐				
DEP					☐	☐	☐				
DEP					☐	☐	☐				
DEP					☐	☐	☐				

Other Health / Dental Insurance Information

Are you or any dependent(s) receiving benefits under Medicare? ☐ No ☐ Yes Eff Date: Part A _____ Part B _____

Medicare #: _____

Do you or any dependent(s) have health/dental coverage with another insurer? ☐ No ☐ Yes Eff Date: _____

Term Date: _____ Carrier Name: _____ Policy #: _____

Policyholder Name: _____ ☐ Individual Policy ☐ Spouse's Employer

Benefit Elections – Check off Plan Type, Enter Plan Description and Benefit / Amounts where needed

☐ MEDICAL PLAN: _____ ☐ MEDICAL PLAN: _____

☐ MEDICAL PLAN: _____ ☐ MEDICAL PLAN: _____

☐ HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN: _____

☐ DENTAL PLAN: _____ ☐ DENTAL PLAN: _____

☐ VISION PLAN: _____ ☐ VISION PLAN: _____

☐ GROUP LIFE ☐ GROUP AD&D ☐ GROUP SHORT TERM DISABILITY ☐ GROUP LONG TERM DISABILITY

☐ EMPLOYEE SUPP LIFE BENEFIT AMOUNT: _____ ☐ EMPLOYEE SUPP AD&D BENEFIT AMOUNT: _____

☐ SPOUSAL SUPP LIFE BENEFIT AMOUNT: _____ ☐ SPOUSAL SUPP AD&D BENEFIT AMOUNT: _____

☐ DEPENDENT LIFE BENEFIT AMOUNT: _____ ☐ DEPENDENT AD&D BENEFIT AMOUNT: _____

☐ VOLUNTARY STD BENEFIT AMOUNT: _____ ☐ VOLUNTARY LTD BENEFIT AMOUNT: _____

CERTIFICATION: ***If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Membership Services Representative before signing this election form.***

I hereby enroll on behalf of myself and each dependent listed on the election form. If this form is accepted, coverage will be provided according to the terms and conditions of the contract between the carrier and my employer. I agree to pay current and future charges for the coverage provided in excess of any employer contribution. Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I have carefully read this form and agree to its terms. The recorded answers on this form are, to the best of my knowledge and belief, full, complete and true as of this date. I certify that I am the spouse, parent, legal guardian (or the dependent has been placed in my home for adoption) of the dependents listed on the form and they are dependent upon me for primary support, as defined by the IRS.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

EMPLOYER SIGNATURE: _____ **DATE:** _____

ACCOUNT #: _____ EFFECTIVE DATE: _____

LAST NAME _____ FIRST NAME _____ MI ____ SSN _____

Waiver of Coverage ☐ Not Interested ☐ Group Coverage Elsewhere - Carrier Name: _____
☐ Medicare/Medicaid ☐ Individual Coverage Elsewhere ☐ Out of Carrier Service Area ☐ Federal Subsidy/Public Exchange

I hereby certify that the benefits provided by my Employer have been explained to me, that I have been given an opportunity to elect coverage and that I voluntarily decline to participate in the benefits offered. I understand that I may be required to wait until the next open enrollment period or until a Special Enrollment event for medical or dental coverage occurs, or be required to provide Evidence of Insurability for life or disability benefits. I certify this election as per the certification statement shown on the applicable page of this application.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Life Insurance – Beneficiary Information

	Group Life/AD&D Beneficiary Name	**Relationship**	**Percentage**
Primary			
Primary			
Contingent			
Contingent			

	Voluntary Employee Life/AD&D Beneficiary Name	**Relationship**	**Percentage**
Primary			
Primary			
Contingent			
Contingent			

	Voluntary Spousal Life/AD&D Beneficiary Name	**Relationship**	**Percentage**
Primary			
Primary			
Contingent			
Contingent			

	Voluntary Dependent Life/AD&D Beneficiary Name	**Relationship**	**Percentage**
Primary			
Primary			
Contingent			
Contingent			

Amwins Connect Administrators Advantage HRA – Important Information

Elections under the HRA plan are binding for the entire Plan Year and cannot be revoked, modified or amended unless due to a limited family status change. Under penalty of perjury, you agree to use the debit card solely for the purchase of eligible expenses not covered by any other plan. You are responsible for providing proof to support reimbursed expenses and agree that any reimbursed expenses later discovered to be ineligible may be deducted from your paycheck by your employer. By electing the HRA plan, you authorize the release of claims information to your employer and Amwins Connect Administrators, the Third Party Administrator for this plan.

EMPLOYEE ELECTION FORM - ADDENDUM

(This is not an application for insurance)

EMPLOYER: _____ EFFECTIVE DATE: _____

ACCOUNT #: _____

LAST NAME _____ FIRST NAME _____ MI ____ SSN _____

Coverage Level – Make selections for all covered dependents. Blank boxes indicate no election.

	NAME	DOB	SSN	SEX M/F	MED	DEN	VIS	MEDICAL PCP #	CURR PATIENT Y/N	DENTAL #	DEBIT CARD Y/N
DEP					☐	☐	☐				
DEP					☐	☐	☐				
DEP					☐	☐	☐				
DEP					☐	☐	☐				
DEP					☐	☐	☐				

Benefit Elections – Enter Additional Plan Description and Benefit / Amounts where needed

☐ ADDITIONAL PLAN: _____ BENEFIT AMOUNT: _____

☐ ADDITIONAL PLAN: _____ BENEFIT AMOUNT: _____

☐ ADDITIONAL PLAN: _____ BENEFIT AMOUNT: _____

☐ ADDITIONAL PLAN: _____ BENEFIT AMOUNT: _____

Life Insurance – Additional Beneficiary Information

Plan: _____ **Relationship** **Percentage**

Primary _____ _____ _____

Primary _____ _____ _____

Contingent _____ _____ _____

Contingent _____ _____ _____

Plan: _____ **Relationship** **Percentage**

Primary _____ _____ _____

Primary _____ _____ _____

Contingent _____ _____ _____

Contingent _____ _____ _____