ONLY USE THIS FORM IF MAKING CHANGES

NORTHERN DIVISION

GRADY MANAGEMENT, INC.
Exceptional People. Exceptional Communities.

EMPLOYEE GROUP BENEFITS ELECTION FORM

December 1, 2020 to November 30, 2021

☐ New Enrollee ☒ Open Enrollment ☐ Re-Hire ☐ Coverage Change ☐ Add/Cancel Dependents

Last Name	First Name	M.I.	EFFECTIVE DATE: 12/1/2020
Mailing Address			Employer: Grady Management
City	State	Zip	Gender: ☐Male ☐Female
Home Telephone #	Cell Telephone #	Marital Status: ☐S ☐M	Date of Marriage (if adding new spouse)
Employee Email	Full-time Hire Date	Hours Worked Per Week (avg.)	

MEDICAL PLANS: CAREFIRST (Grp#DC10)
Select ONE Medical Plan

BlueChoice HMO

Choose Tier - Cost per month:

☐ Employee Only	$90.00
☐ Employee + 1	$185.00
☐ Family	$480.00
☐ Waive Coverage* (Check box below)	

BlueChoice HMO Open Access

Choose Tier - Cost per month:

☐ Employee Only	$175.00
☐ Employee + 1	$285.00
☐ Family	$610.00
☐ Waive Coverage* (Check box below)	

DENTAL PLAN: MetLife

Choice Tier	Cost per mo:
☐ Employee Only	$5.00
☐ Employee +1	$35.00
☐ Family	$53.00
☐ Waive Coverage	

ANCILLARY COVERAGE: MetLife
(applies to full-time employees only)

- Base Life/AD&D (Paid by Grady Management)
- Long-term Disability Insurance (Paid by Grady Management)

A separate Beneficiary Form is required

***Waiver of Coverage: I certify that group insurance coverage has been offered to me and I choose to waive coverage due to:**
☐Spousal Coverage ☐Individual Coverage ☐ Military Coverage ☐COBRA ☐Medicare as primary under TEFRA ☐No Coverage (See Reverse for info)

Last, First, M.I.	Social Security Number	Birth Date	Sex (M/F)	Disabled (Y/N)	Primary Care (PCP) Name	PCP ID # (look up at www.carefirst.com)
Emp						
Sp						
Chd						
Chd						
Chd						

OTHER/PRIOR HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare.
Do you or your dependents have other/prior Health coverage with another insurer? ☐No ☐ Yes
if Yes: Effective Date:_____ Carrier Name _____Policy #_____
Will this coverage be continued? ☐Yes ☐No If No: Term. Date: _____
Are you covered by Medicare? ☐No ☐Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__ Medicare #_____
Is your spouse or dependent(s) covered by Medicare? ☐No ☐Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__
Name of spouse or dependent(s) covered (if applicable): _____Medicare #_____

AUTHORIZATION: I hereby apply for the coverages for which I am entitled under the terms of the Grady Management Benefits Programs and I agree to pay any required costs through payroll deductions on a pre-tax basis, if eligible. I understand I cannot change my elections during the year unless I have a Qualified Change in Family Status or I meet the plans Special Enrollments requirements. Coverage shall become effective solely upon final approval by the carriers and not from the collection of premiums. I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above.
FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is committing a fraudulent act which is a crime and subjects such person to criminal and civil penalties as well as termination of employment.

EMPLOYEE SIGNATURE _____DATE_____

If you have any questions concerning the benefits and services that are provided by or excluded under the plans offered, please contact a membership services representative or Human Resources before signing this form.

Waiver of Insurance Coverage

Medical- Notice of Special Enrollment Period

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependent(s) in this plan in the future, provided that you request enrollment within 30 days of the termination date of your prior coverage. If you decline enrollment for yourself or your dependent(s) because of other health insurance coverage, you must complete the section titled ***"Other Health Insurance"*** on the Election Form to preserve your future enrollment rights.

If you decline coverage for yourself or a dependent(s) because of other health coverage and do not complete the ***"Other Health Insurance"*** section on the Election Form (or provide written proof from the other plan), or do not request enrollment within 30 days after your (and/or) dependents' other coverage ends, you will not be eligible to enroll yourself or your dependent(s) during the enrollment period discussed above. You will then need to wait until the next open enrollment period (if applicable) to enroll in the plan's health coverage.

If you are currently declining coverage for you or your dependent(s), you can enroll yourself and/or your dependent(s) at a later date in accordance with the following special enrollment provisions:

- **You and/or your dependent(s) are no longer eligible under your spouse's coverage:**
  - because your spouse's employment or his/her group had been terminated;
  - you are divorced from your spouse; or
  - due to the death of your spouse.

- **You are no longer eligible under your parent's coverage.**

- **You and/or your dependent(s) have coverage through another group but later become ineligible for coverage through the group (including COBRA participants).**

- **Your group health plan may also allow employees who are already enrolled for coverage to add dependents upon marriage, birth, adoption, and placement for adoption.**

Please contact your Group Administrator for more detailed information on your group's Special Enrollment Provisions.

Non-Medical

If you are voluntarily declining the non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the availability of coverage, which is now being waived.

Life/Disability: if you waive life or disability and later decide to enroll, the carrier may require you to provide, at your own expense, proof of insurability. Late enrollment may cause an increase in cost and submission of a health questionnaire. Carriers reserve the right to reject late entrant requests.

Dental: if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your benefits may be limited for a period of time. The carrier may waive late entrant penalties if you lose coverage due to a termination of the plan, loss of employment, death of a spouse or where a court has ordered coverage be provided for an eligible children, provided you apply within 30 days of the lifestyle change.