THE DEPAUL GROUP

Universal Enrollment Form 2024 - 2025

(Medical, Dental, Vision and Company Paid Life Insurance)

1. COMPANY – Check One

☐ Tony DePaul and Son ☐ St. Thomas ☐ County Line Quarry ☐ DePaul Realty ☐ Woodview
☐ Highway Materials, Inc. ☐ TDPS ☐ Judd Builders ☐ DePaul Healthcare Corporate ☐ Rose Hill
☐ HMIC ☐ DePaul Corporate ☐ Spring Mill Country Club ☐ Terraces at Parke Place

2. REQUEST TYPE – Check One

☑ Open Enrollment
☐ New Hire
☐ Part-Time to Full Time
☐ Update/Change in Beneficiary for Company Paid Life/AD&D Insurance
☐ Change in Life Event (type of event) ________________ Date of Event ___/___/___
(Documentation is required to support the Qualified Life Event.)

3. EMPLOYEE INFORMATION – Please Print

Employee Name	Gender: ☐ Male ☐ Female	SSN	Date of Birth	Date of Hire

Home Address	City	State	Zip

Personal Email Address	Home Phone	Cell Phone

4. COMPANY PAID LIFE INSURANCE – Beneficiary Information *(for Life and AD&D)*

<u>Primary Beneficiary Designation</u>

Primary beneficiary will receive 100% of benefit unless you elected multiple beneficiaries. When electing multiple beneficiaries, make sure a percentage for each beneficiary is identified and use a separate sheet of paper to list.

Name of Primary Beneficiary	SSN	Relationship	Percentage

Address	City	State	Zip Code	Phone

<u>Contingent Beneficiary Designation</u>

Contingent beneficiaries become effective only when all primary beneficiaries have died at the time the benefit is to be paid. Multiple contingent beneficiaries may be elected; make sure a percentage for each beneficiary is identified and use a separate sheet of paper to list.

Name of Contingent Beneficiary	SSN	Relationship	Percentage

Address	City	State	Zip Code	Phone

5. COMPANY PAID DEPENDENT LIFE INSURANCE – Dependent Information

The company provides life insurance to employee's spouse and dependents (from 6 months to 19 years of age or 25 years of age if fulltime student). If you have dependents, please fill in the information below. The beneficiary for dependent life is the employee.

Spouse Name	DOB	SSN	☐ Male ☐ Female	
Child Name	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)
Child Name	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)
Child Name	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)

6. HEALTH PLAN CHOICES – Choose one option

OPTION 1 - MEDICAL, DENTAL AND VISION BUNDLE

A. Coverage Level (Choose One)	Tier level will be the same for all coverage. ☐ Single ☐ Employee & Child ☐ Employee & Children ☐ Employee & Spouse* ☐ Employee & Family* **If electing benefits for the first time & covering a spouse, a copy of your marriage license is required.*
B. Medical Plan (Choose One)	☐ Independence Blue Cross Consumer Driven Health Plan (CDHP) #1 ☐ Independence Blue Cross Consumer Driven Health Plan (CDHP) #2 ☐ Keystone/AmeriHealth HMO *(PCP required, complete information below)* Primary Care Office/PCP Name / Primary Care Office ID# Street Address / Phone Number ☐ Keystone/AmeriHealth POS *(PCP required, complete information below)* Primary Care Office/PCP Name / Primary Care Office ID# Street Address / Phone Number ☐ Independence Blue Cross Personal Choice (PPO)
C. Dental Plan (Choose One)	☐ AETNA Dental PPO/PDN ☐ AETNA DMO/DNO *(PCP required, complete information below)* Primary Care Office/PCP Name / Primary Care Office ID# Street Address / Phone Number
D. Vision Plan	Automatic enrollment in Vision Benefits of America

OPTION 2 - DENTAL AND VISION ONLY; WAIVE MEDICAL

A. Coverage Level (Choose One)	Tier level will be the same for all coverage. ☐ Single ☐ Employee & Child ☐ Employee & Children ☐ Employee & Spouse* ☐ Employee & Family* **If electing benefits for the first time & covering a spouse, a copy of your marriage license is required.*
B. Dental Plan (Choose One)	☐ AETNA Dental PPO/PDN ☐ AETNA DMO/DNO *(PCP required, complete information below)* Primary Care Office/PCP Name / Primary Care Office ID# Street Address / Phone Number
C. Vision Plan	Automatic enrollment in Vision Benefits of America

OPTION 3 – WAIVE ALL COVERAGE

☐ Waive medical, dental and vision coverage

7. HEALTH SAVINGS ACCOUNT

Health Savings Account – HSA	Only available if you enroll in the CDHP#1 or CDHP#2 Maximum allowable contribution for 2024: Single Coverage - **$4150** / Family Coverage - **$8300** Additional 'Catch-up' allowed for those 55 years of age or older - **$1000** Contribution amount each pay: $________

8. COVERED EMPLOYEE AND DEPENDENT INFORMATION

Employee Name*

*PRINT NAMES EXACTLY AS THEY APPEAR ON YOUR SOCIAL SECURITY CARD

Spouse Name*	DOB	SSN	☐ Male ☐ Female	
Dependent Name*	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)
Dependent Name*	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)
Dependent Name*	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)
Dependent Name*	DOB	SSN	☐ Male ☐ Female	Address (if different from employee's)

9. EMPLOYEE AUTHORIZATION

By signing below:

- I understand that my benefit choices cannot be changed for the coming Plan Year, 8/1/2023-7/31/2024 (unless I have an IRS approved qualified event and notify The DePaul HR Department in writing of same within 31 days) and until I make a new election during the annual Open Enrollment period.
- I have received and read the printed material explaining the DePaul Group Benefits Program and my choices under the program.
- I am authorizing The DePaul Group to take the necessary contributions from my pay for the benefits elected. I understand that benefit contributions will be taken out each payroll period on a BEFORE-TAX basis.
- **If WAIVING MEDICAL COVERAGE, my signature below certifies that I choose not to participate in the DePaul Medical Plan and have secured medical insurance elsewhere. I also acknowledge that I have been offered a plan by the group that meets the minimum essential coverage and value standard required by the government.**
- I certify that the information I have provided is true and correct to the best of my knowledge. I understand that any false statements (dependent status, date of birth, social security number, etc.) could result in termination of coverage for me and any of my dependents.

Employee Name – Please Print	
Employee Signature	Date