aetna℠

MedPremier
Enrollment/Change Request

Insurance plans are underwritten and administered by Aetna Life Insurance Company (Aetna).

LOGMET LLC
Standard Plan

Instructions: Read and fill out the Enrollment/Change Request (all pages). Make a copy for yourself. Give the original to your employer.

INFORMATION ABOUT YOU Complete all information.

Print your name (first, middle initial, last)			Social Security Number	Date of birth (MM/DD/YYYY)
Home address	Apartment Number	City	State	Zip code
Home phone ( )	Work phone ( )	Email address	Sex ☐ Male ☐ Female	Primary language spoken (Idioma principal)

ACTION YOU WANT TO TAKE Check the box next to the action you want to take.

I am not currently enrolled and I want to…	☐ **Enroll** in the coverage choices selected below.
I am currently enrolled and I want to…	☐ **Update** my personal and/or my dependent and/or beneficiary information.

YOUR COVERAGE CHOICES Check (☑) the box for the level of coverage you want.

Base Plan
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family

Buy Up Plan*
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family

**If you elect to enroll in the Buy Up Plan, there will be a $70.70 monthly payroll deduction for this elective enriched coverage option.*

EMPLOYER GROUP INFORMATION This section is to be completed by your employer.

Employee ID	Hire date (MM/DD/YYYY)	Pay type	Total deduction ($)	**Effective date** (MM/DD/YYYY)
Location or site code	Authorized signature		Title	Today's date (MM/DD/YYYY)

INFORMATION ABOUT YOU
Repeat your name and Social Security number here.

Print your name (first, middle initial, last)	Social Security Number

INFORMATION ABOUT YOUR DEPENDENTS
List the dependents for whom you are adding/changing/removing coverage.

If you have more dependents, write down their information on a separate sheet and attach it to this Enrollment/Change Request.

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last)		Social Security Number	
Sex ☐ Male / ☐ Female	Date of birth		
Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): ____			
Address (if different than yours)	City	State	Zip code

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last)		Social Security Number	
Sex ☐ Male / ☐ Female	Date of birth		
Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): ____			
Address (if different than yours)	City	State	Zip code

☐ Add ☐ Change ☐ Remove

Print dependent's name (first, middle initial, last)		Social Security Number	
Sex ☐ Male / ☐ Female	Date of birth		
Relationship: ☐ Spouse ☐ Domestic partner ☐ Child ☐ Other (Specify): ____			
Address (if different than yours)	City	State	Zip code

MAKING CHANGES OUTSIDE OF AN OPEN ENROLLMENT
Please read below to see if you are able to make changes to your coverage.

You can add to or increase your coverage during the plan year only if you have a **Qualifying Life Event (QLE)**. QLEs fall under one of these two categories:

Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be able to enroll yourself and your dependents. If you had a recent LOC, go to the list on the right and check the box next to your LOC and supply the date of the LOC.

Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be able to add or increase coverage when you experience certain FSC events. If you had a recent FSC, go to the list on the right and check the box next to your FSC and supply the date of the FSC.

Next, complete the rest of this Enrollment/Change Request. When finished, make a copy and submit it to your employer with your documentation attached. You must submit this Enrollment/Change Request, together with documentation, to your employer within 31 days of the LOC/FSC.

Loss of Other Coverage (LOC):
- ☐ Divorce, legal separation or death
- ☐ Termination of employment of a dependent
- ☐ Reduction of a dependent's hours
- ☐ Termination of your or your dependents' COBRA rights
- ☐ Loss of employer's contribution to spouse's or domestic partner's coverage
- ☐ Dependent child losing eligibility as a dependent
- ☐ Other loss of coverage

Family Status Change (FSC):
- ☐ Divorce, legal separation or death
- ☐ Marriage
- ☐ Birth or adoption of a dependent
- ☐ Other

Date of LOC or FSC (mm/dd/yyyy)

YOUR AUTHORIZATION
You must sign and date this Enrollment/Change Request for all new enrollments or coverage changes.

I represent that all information supplied in this Enrollment/Change Request is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the last page of this Enrollment/Change Request.

Your signature	Today's date (MM/DD/YYYY)	Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If "Yes," please indicate the nature of your disability. ____

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

On behalf of myself and the dependents listed on this Enrollment/Change Request, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten and administered by Aetna Life Insurance Company (Aetna) 151 Farmington Avenue, Hartford, CT 06156.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. **Misrepresentation:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
   Attention Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
   Attention Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company
Administered By **Boon Administrative Services, Inc.**
6300 Bridgepoint Parkway, Building 3, Suite 500
Austin, TX 78730

Beneficiary Designation Form

Applicant (Last, First, M.I.)	Social Security No.	Product

Beneficiary (Last, First, M.I.)	Beneficiary Type*	%	Relationship	Social Security No.	Date of Birth
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				
	☐ Primary ☐ Contingent				

*Primary Beneficiary is the first to receive the benefit. Contingent Beneficiaries receive the benefits in the event the Primary Beneficiary is no longer living at the time the insured dies.

Insured Signature: _____ Date: _____

Please return all benefits related forms to Boon Administrative Services, Inc., your Benefits Administrator:

Boon Administrative Services, Inc.
6300 Bridgepoint Parkway
Building 3, Suite 500
Austin, TX 78730
(512) 339-6662 fax

Please allow 72 hours for processing.
Questions? Call Customer Service toll-free at (866)337-8417

Waiver of Group Health Plan Coverage

Company Name **Logmet LLC**	Jobsite Location	Date of Hire
Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth
Home address		
City	State	Zip code

As a Full Time employee of of **Logmet**, you are automatically enrolled in "Employee Only" coverage under the *Aetna MedPremier Major Medical Health Plan***.** If you are currently covered under another Employer-Sponsored Major Medical Group Health Plan and wish to waive your coverage as an employee of of **Logmet**, **you must submit this completed Benefit Election Waiver and proof of an acceptable alternative coverage** during the open enrollment period **TBD**.

The following coverage types **do not** qualify as an acceptable alternative to waive **Logmet's** *Aetna MedPremier Major Medical Health Plan* coverage: Tricare; Medicare; Indian Health Services (IHS); individual plans (non-Employer Sponsored plans), including individual Qualified Health Plans purchased through a state or federal Affordable Care Act Exchange or Marketplace. **For more information, refer to 32 C.F.R. §199 and 42 U.S.C. §1395y(b)(3).**

Proof of acceptable alternative coverage is required. Please make a copy of the front and back of your current insurance identification card and attach the copy to this form for verification purposes. Your name must be visible on the card. If your name is not visible on the card, provide a letter, on the insurance provider's letterhead, from the insurance provider confirming that you are covered by the plan.

To waive coverage, initial **all** of the following statements:

- For the plan year effective ____/____/_____, I am waiving coverage under the of **Logmet** *Aetna MedPremier Major Medical Health Plan*, because I have **active** coverage under another Employer-Sponsored Major Medical Group Health Plan, Medicaid or Veterans Administration (VA) coverage with a letter of credible coverage (not all types of VA coverage are ACA compliant).. *Initial:* _____

- I understand that if I do not submit the completed benefit waiver and the required supporting documentation within the timeframe indicated above, I will not be allowed to waive coverage, and I will not be given another opportunity to waive this coverage until a subsequent open enrollment period or until I experience a qualifying life event (QLE). *Initial:* _____

- I understand that choosing to waive employer-sponsored group health plan coverage may lead to disqualification for, loss of, or repayment of any tax credits or subsidies used to purchase an individual Qualified Health Plan through a state or federal Exchange/Marketplace. *Initial:* _____

- I understand that by choosing not to participate in the company's group health plan, the *Aetna MedPremier Major Medical Health Plan*, I am waiving coverage under the plan available to me through of **Logmet.** I understand that in order to waive coverage, my supporting documentation, for of an acceptable alternative coverage, must fulfill the requirements stated above. I also understand that I am making a binding election with respect to my benefits and that I will not have an opportunity to enroll in the plan until next open enrollment period or unless I experience a qualifying life event. *Initial:* _____

- **I have** read or had read to me the completed waiver form. **I represent** that all statements and answers made on or attached to this waiver form are true to the best of my knowledge and belief. *Initial:* _____

Signature of Employee **Date of Signature**

Mail form to: The Boon Group, Attn: Govt. Enrollment, 6300 Bridgepoint Pkwy, Bldg. 3, Suite 500, Austin, TX 78730
Or **Fax** form to: (512) 339-6662 Attn: Government Enrollment