KELLY

For Benefit Information Please Visit:
https://right-resources.com/temporary-benefits/

RIGHT resources
...because who you work with matters.

☐ New Subscriber ☐ Member adding line of coverage ☐ WAIVER (*Signature Required*) ☐ COBRA or State Continuation ☐ Retiree

Company Name:		**KELLY Company ID:**		**Business Phone:**	

1 EMPLOYEE

Last Name	First Name	MI	Suffix (Jr., Sr., etc.)

Street *Note: a PO Box is insufficient for any HSA, FSA, or HRA account*	Apt #

City	State	Zip Code	E-mail

Social Security #	Date of Birth (MM-DD-YY)	Gender M ☐ F ☐	Marital Status Single ☐ Married ☐ Partner* ☐	On your effective date, will you be actively at work on a full-time basis for this employer? Y ☐ N ☐	Hrs/week

Home Phone	Full-time Hire Date (MM-DD-YY)	***Employer Use Only:***	Requested Effective Date (MM-DD-YY)	KELLY USE ONLY: H

** Domestic partner coverage availability is based on carrier and employer authorization.*

2 DEPENDENTS

Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Sex	F/T Student (Y/N)**	Disabled (Y/N)	Dependent Elections Health	Dependent Elections Dental	Dependent Elections Vision	Primary Care Physician (POS or HMO plans only) Physician Name	Primary Care Physician (POS or HMO plans only) PCP ID#	Existing Patient (Y/N)
	Subscriber											
							☐	☐	☐			
							☐	☐	☐			
							☐	☐	☐			
							☐	☐	☐			

*** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)*

Participating Dentist Name/Code/Office#: Existing Patient: ☐ Y ☐ N

If Eligible for Medicare: Effective Date (Part A): Effective Date (Part B): Effective Date (Part D):

3 PLANS

Health Plans

- ☐ **UHC Choice Silver BOWK $4500**
- ☐ **UHC Choice Plus Gold BOYS $1750**
- ☐ **UHC Choice Plus Platinum BOYZ $0**

Coverage Level:

- ☐ **Individual**
- ☐ **Individual & Child(ren)**
- ☐ **Individual and Spouse**
- ☐ **Family**
- ☐ **Waive Coverage**

Dental Plans

- ☐ **MAC 7976**
- ☐ **UCR 7977**

Coverage Level:

- ☐ **Individual**
- ☐ **Individual & Child(ren)**
- ☐ **Individual and Spouse**
- ☐ **Family**
- ☐ **Waive Coverage**

Vision Plans

Coverage Level:

- ☐ **Individual**
- ☐ **Individual & Child(ren)**
- ☐ **Individual and Spouse**
- ☐ **Family**
- ☐ **Waive Coverage**

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name: _____

Who is covered? ☐ Self ☐ Spouse/Partner ☐ All Policy# _____

Effective Date: Term Date:

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that the dependents listed above are eligible to enroll in the plan(s) selected. I have read and understand the second page of this form, including the sections titled The Role of Kelly and Waiver of Insurance, which are incorporated here by reference. **If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.** **THIS IS NOT AN APPLICATION FOR INSURANCE**

6

EMPLOYEE SIGNATURE:	**DATE:**
EMPLOYER SIGNATURE / VERIFICATION:	**DATE:**

8/5/15

1 Kelly Way · Sparks, Maryland 21152 | (T) 410 527 3432 | (F) 410 527 5905 | enrollmentfax@kellyway.com

www.kellyway.com

KELLY & ASSOCIATES INSURANCE GROUP, INC.

WAIVER OF INSURANCE COVERAGE

Medical/Dental/Vision/Medicaid & State Children's Health Insurance Program (SCHIP) - Notice of Special Enrollment Period:

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during open enrollment period, if applicable. In Washington DC, a civil union spouse is recognized as a marital spouse. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days for Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Non-Medical:

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events: 1)Marriage, divorce, or legal separation; 2) Birth or adoption of a child; 3) Death of a spouse or child; 4) Change in residence or work location that affects benefits eligibility for you or your covered dependent(s); 5) Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes); 6) You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job); 7) Loss or eligibility for Medicaid or SCHIP Coverage.

Notice to the Insured: The insurance carrier sells insurance products pursuant to which eligible employees of the policyholder may obtain coverage. Kelly & Associates Insurance Group, Inc. actively administers the insurance carrier's health insurance program. Premiums are made by the policyholder to KELLY on behalf of eligible employees. These amounts are then forwarded to the insurance carrier that provides the benefits for the eligible employee. KELLY is authorized by the insurance carrier to perform the following functions for group health benefit plans and all other insurance products issued, administered or marketed by the insurer: process enrollment activity; collect premiums and remit payments to the carrier; and answer questions pertaining to enrollment activity, invoice or benefit inquiries.

The Role of KELLY: KELLY is not the Employer, plan sponsor, insurance carrier, plan administrator or plan fiduciary under the Employee Retirement Income Security Act of 1974 (ERISA) for any benefits or insurance coverage offered through or described in the Sites. KELLY is not responsible for state and federal disclosure and reporting requests or for complying with existing laws. These responsibilities remain with your Employer. KELLY is a Third Party Administrator providing services to assist in the collection and processing of enrollment data and/or the collection of premiums on behalf of the Carrier from which coverage has been requested. KELLY has no underwriting or claims paying functions. KELLY has no authority to underwrite or bind coverage. All decisions as to requests for additional information used to make decisions whether to bind coverage, the binding of coverage, the level of coverage provided, or the payment or denial of claims are made solely by the Carrier. KELLY has no role in making these decisions. Any coverage bound is a contract between the participating Employee, the Employer and the Carrier. KELLY is not a party to that contract. The Carrier from which the participating Employee has requested coverage will rely on the information provided during the enrollment process. KELLY will transmit the data to the Carrier(s) "as-provided". KELLY is not responsible for any determinations made based on the information provided by the participating Employee during enrollment or in response to any subsequent inquiry by the Carrier. The Carrier may require additional information, forms and/or documents, amongst other potential items [such as Evidence of Insurability (EOI)] , from the participating Employee and/or any other person for which the participating Employee is requesting coverage prior to making a decision as to what, if any, coverage the Carrier will provide. Following directions from the Carrier and providing the requested information in a timely manner is of critical importance. The deduction of premiums from the participating Employee's pay does not in and of itself guarantee that any coverage, or coverage at the levels requested, has been bound and is in effect. This provision shall survive termination of this Agreement.

Beneficiaries:

A beneficiary is a person who is designated by a policyholder to receive the benefits/funds from an insurance policy. A primary beneficiary is the beneficiary who is first in line to receive named benefits. Primary beneficiaries are contrasted with secondary/contingent beneficiaries, who are an alternative choice to receive the benefits if the primary beneficiary is not alive to accept the benefits at the time of a claim. A policyholder may name more than one primary beneficiary and more than one secondary beneficiary. In naming more than one, the policyholder must assign a percentage to each additional primary and/or secondary beneficiary to designate the portion of the funds that will be paid out to each beneficiary.

HIPAA:

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, the carrier may use and disclose Protected Information for payment, treatment, and health care operations as described by their Notice of Privacy Practices. I understand that a copy of the carrier Notice of Privacy Practices may be obtained on their websites or by calling the customer service number on the back of the identification card.

Fraud Warning:

MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the law.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

PA: 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.

Notice of Nondiscrimination and Accessibility:

KELLY complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KELLY does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

KELLY:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact KELLY Corporate Compliance (compliancegroup@kellyway.com).

If you believe that KELLY has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: KELLY Corporate Compliance, 1 Kelly Way, Sparks, MD 21152, compliancegroup@kellyway.com, telephone (443) 589-1980.
You can file a grievance in person or by mail, or email. If you need help filing a grievance, KELLY Corporate Compliance (compliancegroup@kellyway.com) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-804-0486.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-804-0486。

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-804-0486 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-804-0486.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-804-0486.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-804-0486.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-804-0486.

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 855-804-0486.

Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ (Bassa)
Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 855-804-0486.

Igbo asusu (Ibo)
Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 855-804-0486.

èdè Yorùbá (Yoruba)
AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 855-804-0486.

(اُردُوUrdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کیخدمات مفت میں دستیاب ہیں ۔ کال کریں 855-804-0486 .

(فارسیFarsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-804-0486 تماس بگیرید.

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 855-804-0486.

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855-804-0486.