OFFER OF COVERAGE

(For current employees who are enrolled in, or have previously been offered enrollment in, the medical plan)

Employee Name: _____ Date: _____

Employee ID Number: _____ Date of Hire: _____

Eligibility. We offer this coverage as indicated in the boxes checked below:

☐Full time employees (30 or more hours per week)

☐Part time employees. To be eligible as a part-time employee, you must work at least _____ hours per week, and you must complete 600 hours of service before you become eligible. You must also complete any period below.

☐Dependent children until age 26

☐Spouse

☐However, we do not offer coverage to a spouse if:

☐He or she is eligible to enroll in other employer coverage (whether or not actually enrolled)

☐He or she is enrolled in other employer coverage

Coverage options. We are pleased to offer the benefits listed below:

Plan Name	Employee-only	Employee + spouse	Employee + children	Employee + family
HMO ___	$	$	$	$
PPO ___	$	$	$	$
POS ___	$	$	$	$

(Note: these plan options are listed only as examples. Please insert the options you offer and complete the premium structure you have adopted for your employees.)

Dental. We offer dental coverage as indicated below:

☐ Plan 275: Orthodontics (Children only)

☐ Plan 274: Orthodontics (Adult and children)

Life Insurance. We offer employee life insurance in the following amounts:

☐ One (1) times salary

☐ Two (2) times salary

☐ Two and a half times (2.5) salary

☐ $10,000

☐ $25,000

☐ $50,000

*Maximum of $350,000. All principal amounts of life insurance for each eligible employee have an equal corresponding amount of accident death and dismemberment coverage.

We also offer dependent life insurance in the following amounts:

☐ $2,000

☐ $10,000

Long Term Disability Coverage. We are pleased to offer long term disability coverage.

Long Term Disability Elimination Period: ☐ 90 days ☐ 180 days

Coverage Effective Date. For new employees, you must complete any probationary period plus a waiting period. Your coverage will become effective as of the date indicated in the box checked below:

☐The first day of the first month

☐The first day of the second month

☐The first day of the third month

after you meet these requirements, or if checked above, after you meet the eligibility requirements for a part time employee.

Enrollment Procedures.

We have attached some important information about our coverage. This includes:

- Summaries of Benefits and Coverage
- Uniform Glossary
- Special Enrollment Rights Notice (for new hires only)
- CHIPRA Notice
- Women's Health and Cancer Rights Act Notice

Additional information will be provided if you decide to enroll.

If you wish to enroll, you should submit your enrollment materials to [Name, contact information] no later than [DATE]. If you submit your materials by that date, your coverage will become effective on [DATE]. By enrolling in the plan you authorize us to withhold your required contributions from your paychecks while your coverage is in effect.

If you decide not to enroll at this time, you should know that you will not have another chance to enroll until January 1 of next year or upon the occurrence of a "special enrollment event" as described in the Special Enrollment Rights Notice. Please sign below to acknowledge that you have received this offer of coverage.

Employee Signature: **Date: _____**

_____

Note: This Offer of Coverage describes important information about your rights to elect health insurance coverage and other benefits. Please keep a copy for your records.