

2011 ENROLLMENT FORM

NAME	DOB	SOCIAL SECURITY #	
DEPARTMENT	BEN DATE	PHONE #	
HOSP#	ADDRESS:		
BENEFIT OPTIONS	COVERAGE TYPE CIRCLE ONE	PLAN #1 (\$450 DEDUCTIBLE) BI-WEEKLY COST	PLAN #2 (\$1,400 DEDUCTIBLE) BI-WEEKLY COST
Medical Premiums (pre-tax)	No Coverage – Go to Page 2	No Cost	No Cost
	Individual	\$40.00	\$17.00
	Employee & Child(ren)	\$106.00	\$75.00
	Employee & Spouse	\$188.00	\$127.00
	Employee & Partner	\$188.00	\$127.00
	Employee & Family	\$211.00	\$140.00
	Employee & Family w/Partner	\$211.00	\$140.00
STATUS:	If FT, no add'l charge		
Full time	IF RPT, add \$25.00		
Wellness Program	Yes or No (Circle one)		
Are you committing to participating in the Wellness Program?	If YES, no charge		
	If NO, add \$20.00		
Any tobacco users on our Medical Plan?	Yes or No (Circle one)		
	If NO, no charge		
	If YES, but all covered tobacco users will commit to completing tobacco cessation, no charge		
	If YES, and you are not committing to tobacco cessation add \$25.00		
TOTAL BI-WEEKLY MEDICAL PREMIUM FOR 2011			\$

Dental Premiums (pre-tax)	No Coverage Individual Employee & Child(ren) Employee & Spouse Employee & Partner Employee & Family Employee & Family w/Partner		N/A \$4.00 \$19.00 \$19.00 \$19.00 \$38.00 \$38.00
Basic Life/AD&D			Enrolled for 1x Annual Salary
Supplemental Employee Life Premiums	No Coverage 1 x salary 2 x salary 3 x salary 4 x salary		No Cost See Attached Rate Sheet
Dependent Life Premiums (If enrolling Spouse for \$50,000 you must complete an EOI form.) (Available on www.cmmfhealthydecisions.com) If your dependent child is 19 or older, he or she must be a considered a Full-Time student in order to remain on this plan.	\$5,000/Spouse & \$2,000/Child(ren) \$10,000/Spouse & \$5,000/Child(ren) \$20,000/Spouse & \$10,000/Child(ren) \$50,000/Spouse & \$10,000/Child(ren)	No Coverage Child(ren) Spouse or Partner Family or Family with Partner Child(ren) Spouse or Partner Family or Family with Partner Child(ren) Spouse or Partner Family or Family with Partner Child(ren) Spouse or Partner Family or Family with Partner	No Cost 2011 Rates See Attached Rate Sheet

Basic 50% LTD Benefit	ENROLLED	
Supplemental 10% LTD Premiums	Enrolling Yes No	2011 Rates See Attached Rate Sheet
Vision Insurance Premiums (pre- tax)	No Coverage Individual Employee & Child(ren) Employee & Spouse Employee & Partner Employee & Family Employee & Family w/Partner	No Cost \$5.95 \$9.66 \$9.45 \$9.45 \$15.55 \$15.55
Short Term Disability	Call EBM @ 1-800-639-4025 (option #3) to enroll within 31 days of your date of hire.	

SPENDING ACCOUNTS	2011
HealthCare Spending Account (\$100 to \$5000)	<p>Check one:</p> <p><input type="checkbox"/> Benny Card (keep your current Benny Card if you have one)</p> <p><input type="checkbox"/> Automatic Reimbursement</p> <p><input type="checkbox"/> Neither Benny Card or Auto Reimbursement</p>
Dependent Care Spending (\$100 to \$5000)	<p>Central Maine Healthcare will pay 15% of your 2011 election. <u>If your 2009 Tax Return Gross Income shows taxable income of less than \$60,000</u> you must submit the front page of your 2009 Federal 1040 form within 31 days of your date of hire to receive a higher subsidy.</p>

Affidavit

If you are enrolling into the CMH medical plan, please check all that apply.

I am joining the Wellness Plan for 2011 and will receive a \$20 bi-weekly discount off my medical premium.

I am choosing to **NOT** join the Wellness Plan for 2011.M

There are no smokers on my medical coverage and I will receive a \$25 bi-weekly discount off my medical premium.

I acknowledge there is at least one smoker on my medical coverage but each smoker has committed to complete a smoking cessation program by March 1, 2011 and I will receive a \$25 bi-weekly discount off my medical premium.

There is at least one smoker on my medical coverage and we choose not to enroll into smoking cessation.

If you have a domestic partner:

I certify my partner meets the definition of domestic partner as defined by CMH.

By answering above, I commit to the accuracy of this information. I understand falsifying this affidavit can result in loss of coverage, additional premiums, and further disciplinary action up to and including termination.

I authorize the elections I have made and the payments required for those elections. I understand that any payroll deductions will be made from my paycheck. I also understand that the elections cannot be changed unless I have a qualifying event.

YOUR SIGNATURE

DATE

**FORM MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES
WITHIN TWO WEEKS OF YOUR HIRE DATE.**