Medical Coverage Change Form

Employee Name: _____ **Effective Date** ____/____/____

S. S. # XXX - XX - _____ **Date of Birth:** NOT NEEDED AT THIS TIME

Name Change:

From: _____

To: _____

Address Change: _____

_____

_____

Reason Codes: Date: / /

(1) Marriage_____
(2) Divorce/Separation_____
(3) Birth_____
(4) Termination_____
(5) Insurability Approved_____
(6) Spouse's Employment_____
(7) Death_____
(8) Other_____

Adding Dependents

Coverage to be Added ☐ Medical ☐ Dental ☐ Medical/Dental

Name	Relation-ship	S.S. #	Sex F-M	Date of Birth	Student	Employed	Other Coverage
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No

HIPAA: Special Enrollment ____ Late Enrollment ____ Qualifying Event_____

Have you or your dependents had prior health coverage within the last 63 days? ☐ Yes ☐ No If yes please attach certificates of creditable coverage.

Cancellation of Employee/Dependent Coverage

Name	Date of Birth	Last Date of Coverage	Reason Code

Coverage or Plan Change: (i.e., Single to Family)

From	To	Effective Date	Reason Code
		/ /	

X _____ / /

Employee and/or Employer Signature Date

Employer Comments: _____

_____

Recorded/Encoded: _____

T-L Irrigation Co.
2021 Health Insurance Election Form

EMPLOYEE NAME _____

Coverage will be effective on _____

ALL Health Plan Deductions will be on a PRE-TAX BASIS.

PLAN A
TRADITIONAL PPO

	In-Network		Non Network Providers	
	Single	**Family**	**Single**	**Family**
Deductible	$ 600	$1,200	$1,200	$2,400
Maximum OOP	$1,600	$3,200	$3,200	$6,400
Co-Insurance level	20% of the next $5,000		40% of the next $5,000	
Office Visit Copay	$30.00		60% after deductible	
Rx Copay (generic/brand)	$15/$47.50		$15/$47.50	

I ELECT PLAN A

_____ Employee Only Premium **$ 155.00 per Month**
_____ Family Premium **$1,004.00 per Month**

PLAN B
HIGH DEDUCTIBLE HEALTH PLAN, HSA QUALIFIED

	In-Network		Non Network Providers	
	Single	**Family**	**Single**	**Family**
Deductible	$2,800	$5,200	$2,800	$5,200
Maximum OOP	$3,600	$7,200	$4,600	$9,200
Co-Insurance level	20% of the next $5,000		40% of the next $5,000	
Office Visit Copay	Not available		Not available	
Rx Copay (generic/brand)	Not available		Not available	

I ELECT PLAN B

_____ Employee Only Premium **$ 71.00 per Month**
_____ Family Premium **$718.00 per Month**

Under the following circumstances the higher In-Network payment will be made for certain Non-Network services: For those active employees of the Company whose primary place of work is in an area where there is not a contracted network, their benefits will be paid as In-Network; however, the benefits will be subject to Usual and Reasonable Charges. In the event a Network contract is established, employees will be notified in advance.

Signature: _____ Date: _____

T-L Irrigation Co.
2021 Health Insurance Election Form

EMPLOYEE NAME _____

Coverage will be effective on _____

ALL Health Plan Deductions will be on a PRE-TAX BASIS.

PLAN C - Includes preventative coverage
TRADITIONAL PPO

	In-Network		Non Network Providers	
	Single	**Family**	**Single**	**Family**
Deductible	$ 600	$1,200	$1,200	$2,400
Maximum OOP	$1,600	$3,200	$3,200	$6,400
Co-Insurance level	20% of the next $5,000		40% of the next $5,000	
Office Visit Copay	$30.00		60% after deductible	
Rx Copay (generic/brand)	$15/$47.50		$15/$47.50	

I ELECT PLAN C

_____ Employee Only Premium **$ 190.00 per Month**

_____ Family Premium **$1,074.00 per Month**

PLAN D – Includes preventative coverage
HIGH DEDUCTIBLE HEALTH PLAN, HSA QUALIFIED

	In-Network		Non Network Providers	
	Single	**Family**	**Single**	**Family**
Deductible	$2,800	$5,200	$2,800	$5,200
Maximum OOP	$3,600	$7,200	$4,600	$9,200
Co-Insurance level	20% of the next $5,000		40% of the next $5,000	
Office Visit Copay	Not available		Not available	
Rx Copay (generic/brand)	Not available		Not available	

I ELECT PLAN D

_____ Employee Only Premium **$106.00 per Month**

_____ Family Premium **$788.00 per Month**

Under the following circumstances the higher In-Network payment will be made for certain Non-Network services: For those active employees of the Company whose primary place of work is in an area where there is not a contracted network, their benefits will be paid as In-Network; however, the benefits will be subject to Usual and Reasonable Charges. In the event a Network contract is established, employees will be notified in advance.

Signature: _____ Date: _____

Revised 12/2020