ALLIES INC.
An Affiliate of Woods

2021–22
BENEFITS ENROLLMENT FORM

A. EMPLOYEE INFORMATION (PLEASE PRINT)

Name (Last, First, MI) | Employee ID | Social Security Number

Street Address | City | State | Zip

Email Address | Date of Hire ___/___/___

Home Phone | Cell Phone | ☐ Male ☐ Female | ☐ Married ☐ Single | ☐ Divorced ☐ Separated | Date of Birth ___/___/___

B. MEDICAL PLAN OPTION

Please check (✓) one box.
Medical Coverage includes Prescription Drug Coverage

	HOMESTEAD 250/500	HOMESTEAD 1000/2000
Employee Only	☐ $60.45	☐ $55.85
Employee + Spouse	☐ $310.29	☐ $286.71
Employee + Children	☐ $260.93	☐ $241.10
Family	☐ $423.12	☐ $390.96
☐ **Waive Medical Coverage**		

C. DENTAL PLAN OPTIONS

Please check (✓) one box.

	DPPO	DHMO*
Employee Only	☐ $7.14	☐ $1.92
Employee + Spouse	☐ $16.71	☐ $8.39
Employee + Children	☐ $20.73	☐ $10.18
Family	☐ $37.38	☐ $18.58
☐ **Waive Dental Coverage**		

*** If choosing the DHMO Plan, please write the Dentist Office ID# found in the dental directory:** _____.
You can go to any dentist on the PPO plan, just make sure they accept the Delta Dental insurance.

D. VISION PLAN OPTIONS

Please check (✓) one box.

	EYEMED PER PAY PERIOD CONTRIBUTIONS
Employee Only	☐ $2.79
Employee + Spouse	☐ $5.30
Employee + Children	☐ $5.58
Family	☐ $8.20
☐ **Waive Vision Coverage**	

E. DEPENDENT INFORMATION

(Indicate dependents that you want covered by your medical, dental or vision plans)

LAST NAME, FIRST NAME, MI	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	COVERAGE
Spouse/Partner	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision
Child	☐ Male ☐ Female	/ /		☐ Medical ☐ Dental ☐ Vision

If enrolling more than four children, please attach a separate sheet of paper with the above information.

NOTE: Proof of dependent eligibility (marriage license, certificate of domestic partnership, child's birth certificate, etc) must be submitted with enrollment form.

I apply for coverage, as indicated, for which I am or may become eligible through my employment with Allies, Inc. I have read the above statements and represent they are true to the best of my knowledge. If applicable, the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I authorize my employer to deduct from my pay the necessary premiums (if any) to be withheld through payroll deduction and, where allowed, on a pre-tax basis, in equal installments throughout the plan year.

EMPLOYEE SIGNATURE

Signature _____ Date _____

WAIVER OF INSURANCE

I _____, hereby certify that the insurance plans offered by Allies, Inc., have been explained and offered to me. However, by my own free will and without coercion, I have decided to waive my enrollment and refuse insurance coverage for myself and my eligible dependents. I further understand that should I want to enroll myself or my eligible dependents for medical and dental coverage in the future, I and/or my eligible dependents will be required to submit proof of coverage loss through another insurance carrier. If documentation is not submitted, enrollment requests will only be accepted during annual open enrollment each year.

EMPLOYER VERIFICATION (To be completed by employer. Employer signature required.)

Signature _____ Date _____

Effective Date _____