Atlantic Medical Imaging

ELECTION/PAYROLL AUTHORIZATION FORM
November 1, 2014 – October 31, 2015
MEDICAL/RX AND DENTAL

BI-WEEKLY

☐ New Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Other (Please Print)

EMPLOYEE INFORMATION – PLEASE PRINT LEGIBLY

EMPLOYEE NAME	SOC. SEC. NO.	DATE OF BIRTH	DATE OF BENEFITED STATUS
ADDRESS STREET NAME			APT
CITY STATE ZIP			
SPOUSE NAME	SOC. SEC. NO.	DATE OF BIRTH	DATE OF MARRIAGE
CHILD NAME	SOC. SEC. NO.	DATE OF BIRTH	Are you or any covered family members currently eligible for any other coverage? ☐ No ☐ Yes If Yes, please indicate:
CHILD NAME	SOC. SEC. NO.	DATE OF BIRTH	
CHILD NAME	SOC. SEC. NO.	DATE OF BIRTH	
CHILD NAME	SOC. SEC. NO.	DATE OF BIRTH	*Use back of form if additional space is needed*

MEDICAL

Indicate Your Choice With X

☐ **1. I ELECT to participate in the MEDICAL and PRESCRIPTION PLAN**

HEALTH PLAN OPTIONS	CD-HP Bi-Weekly	Gold Bi-Weekly
Employee Only	☐ $5	☐ $60
Employee + Child(ren)	☐ $15	☐ $125
Employee + Spouse	☐ $35	☐ $145
Family	☐ $80	☐ $200

☐ **I DO NOT ELECT to participate in the MEDICAL AND PRESCRIPTION PLAN**

You will receive a $70 per pay credit if you waive medical, prescription and dental coverage. Complete an Opt-Out Form and attach copy of Health Insurance Card.

DENTAL

Indicate Your Choice With X

☐ **1. I ELECT to participate in the DENTAL PLAN**

	BI-WEEKLY CONTRIBUTION
Employee Only	☐ $0
Employee + Child(ren)	☐ $13
Employee + Spouse	☐ $15
Family	☐ $23

☐ **2. I DO NOT ELECT to participate in the DENTAL PLAN**

VISION

Indicate Your Choice With X

☐ **1. I ELECT to participate in the VISION PLAN**

	BI-WEEKLY CONTRIBUTION
Employee Only	☐ $2.95
Employee + 1	☐ $4.73
Employee + Children	☐ $4.83
Family	☐ $7.78

☐ **2. I DO NOT ELECT to participate in the VISION PLAN**

EMPLOYEE AUTHORIZATION:

I have received and read the printed material explaining the Atlantic Medical Imaging Benefits Program and my choices under the program. By signing and returning this election form I am authorizing Atlantic Medical Imaging to take the necessary contribution from my salary for the benefits in which I have enrolled and indicated on this form. I understand that these contributions will be taken over each payroll period on a BEFORE-TAX basis. I understand that my benefit choices will be irrevocable for the coming Plan Year unless I have a change in family status.

EMPLOYEE SIGNATURE _____ **DATE** _____

For plan use only: PR deduction calculation **If Opt-Out Payment:** OO Form and Copy of Card Received ☐

Medical/Rx	Dental	Vision	Total	Division Name	Group #
			0		