

ADMINISTRATION

Instructions to Complete the Employee Benefit Information Sheet

☐ I elect to waive coverage under the HHCA Health and Welfare Plan.

Health & Welfare Benefits Plan:	
Election of Tier 1 Plan (Employee Only)	Please complete the following: - SECTION 1: EMPLOYEE INFORMATION - SECTION 2: COVERAGE ELECTIONS - SECTION 4: OTHER INFORMATION: Sign and Date.
Election of Tier 2 Plan (Employee and Spouse)	Please complete the following: - SECTION 1: EMPLOYEE INFORMATION - SECTION 2: COVERAGE ELECTIONS - SECTION 3: DEPENDENT INFORMATION * Complete Spouse information. * Include a photocopy of marriage certificate. - SECTION 4: OTHER INFORMATION: Complete entire section then Sign and Date.
Election of Tier 3 Plan (Employee and Dependent Children)	Please complete the following: - SECTION 1: EMPLOYEE INFORMATION - SECTION 2: COVERAGE ELECTIONS - SECTION 3: DEPENDENT INFORMATION: * Complete Child information. * If the Child's last name is different from yours, please explain their relationship to you. * Include a photocopy of birth certificate and social security card for each Child. * When adding dependent child(ren) over age 19 and under 26 years of age, you must complete SECTION 5: ENROLLMENT & DEPENDENT ADDITION INFORMATION FORM. In addition, please provide verification (obtained from the Office of Registrar) of student status at an accredited College or University. This must be provided every 6 months for continuous coverage. Notify the plan if non student dependents under 26 years of age may be covered by the plan. * If the Child is a step-child, please refer to the form relating to "Adding and Removing Dependents" available from your employer. - SECTION 4: OTHER INFORMATION: Sign and Date.
Election of Tier 4 Plan (Family)	Please complete the following: - SECTION 1: EMPLOYEE INFORMATION - SECTION 2: COVERAGE ELECTIONS - SECTION 3: DEPENDENT INFORMATION: * Complete Spouse and Child information. * If the Child's last name is different from yours, please explain their relationship to you. * Include a photocopy of marriage certificate. * Include a photocopy of birth certificate and social security card for each Child. * When adding dependent child(ren) over age 19 and under 26 years of age, you must complete SECTION 5: ENROLLMENT & DEPENDENT ADDITION INFORMATION FORM. In addition, please provide verification (obtained from the Office of Registrar) of student status at an accredited College or University. This must be provided every 6 months for continuous coverage. Notify the plan if non student dependents under 26 years of age may be covered by the plan. * If the Child is a step-child, please refer to the form relating to "Adding and Removing Dependents" available from your employer - SECTION 4: OTHER INFORMATION: Complete entire section then Sign and Date.



Metro Waste Authority

We Know Where It Should Go

MUST RETURN TO ACTIVATE HEALTH & WELFARE BENEFIT

HHCA HEALTH & WELFARE PLAN

2600 Grand Avenue, Suite 232

Des Moines, IA 50312-5233

Phone: (515) 402-4422 Fax: (515) 288-9477

Employee Benefit Information Sheet – ADMINISTRATION

This form must be completed fully. Please print clearly or type the information requested.

COVERAGE EFFECTIVE DATE:

SECTION 1: EMPLOYEE INFORMATION

Last Name:	First Name:	Middle Initial:	Date of Birth:
Social Security Number:		Gender ☐ Male ☐ Female	
Street Address:			
City, State, Zip Code:			
Home Phone Number:		Cell Phone Number:	
Email Address:			

SECTION 2: COVERAGE ELECTONS

Medical Benefit Options – Check your election option below:

☐ Election of Tier 1 Plan (Employee Only)
☐ Election of Tier 2 Plan (Employee and Spouse)
☐ Election of Tier 3 Plan (Employee and Dependent Children)
☐ Election of Tier 4 Plan (Family)

SECTION 3: DEPENDENT INFORMATION Please list dependents below: (if you have spouse, child, or family coverage)

	Name: (Last, First, M.I.)	Date of Birth: (M/D/Year)	Sex: (M/F)	Social Security Number:
Spouse			☐ Male ☐ Female	
Child			☐ Male ☐ Female	
Child			☐ Male ☐ Female	
Child			☐ Male ☐ Female	

- NOTE * *Enclose a copy of the state birth certificate for each dependent.* If their last name is different from yours, please explain their relationship to you.
- NOTE *When adding dependent child(ren) over age 19 and under 26 years of age, you must complete the “Enrollment & Dependent Addition Information Form”. In addition, please provide verification (obtained from the Office of Registrar) of student status at an accredited College or University. This must be provided every 6 months for continuous coverage. Notify the plan if non student dependents under 26 years of age may be covered by the plan.

SECTION 4: OTHER INFORMATION:

Spouse Insurance Company	Policy Number
Spouse's effective date of other insurance coverage:	
Date of Marriage:	Enclose a copy of your Marriage Certificate
Signature of Employee:	Date:

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SECTION 5: ENROLLMENT & DEPENDENT ADDITION INFORMATION FORM

Employee Name:	Social Security Number:
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Please return this completed form to include a child less than 26 years of age. All information must be completed and provided or your dependents will not be enrolled under your health care coverage.

FULL TIME STUDENT: If your child is over 19 and under 26 years of age and a Full Time Student at an accredited College or University, please complete the following section to continue coverage in the Plan (please attach copy of verification from the College or University):

Name:	
Social Security Number:	Date of Birth:
Street Address, City, State, Zip Code:	
Phone Number:	

CHILD LESS THAN 26 YEARS OF AGE: If your child is less than 26 years of age, but over 19 years of age and not currently covered in another Health Plan, they are eligible to be considered for coverage under the Plan:

Name:	
Social Security Number:	Date of Birth:
Street Address, City, State, Zip Code:	
Phone Number:	

Signature of Employee:	Date:
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SECTION 6: Kabel Business Services – Flexible Spending Account

Enrollment Information			
☐ New	☐ Renewal	Effective Date:	First Payroll Deduction Date:
Last Name:	First Name:	Middle Initial:	Date of Birth:
Social Security Number:			
Street Address:			
City, State, Zip Code:			
Annual amount of Dependent Care		(Divided by # of Payroll Periods) =	Per Payroll Deduction
Authorization: I certify the above information to be true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care either reside with me in a parent child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire plan year and cannot be revoked unless I experience a change in my family status or termination of employment.			
Signature of Employee:		Date:	
☐ I decline to participate in the Flex Spending account.		Signature of Employee:	
Direct Deposit (Attach a blank voided check if you select Direct Deposit and are a new participant.)			
AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS) I hereby authorize KABEL BUSINESS SERVICES to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated on the attached voided check. This authority is to remain in full force and effect until KABEL BUSINESS SERVICES has received written notice from me of its termination in such time and in such manner as to afford KABEL BUSINESS SERVICES and DEPOSITORY a reasonable opportunity to act on it.			
Signature of Employee:		Date:	



Employer completes next page.



SECTION 7: Kabel Business Services – Health Reimbursement Arrangement – For Internal Use Only

☐ **HRA New Employee**

Employer Name: Metro Waste Authority

Last Name: First Name: Middle Initial:

Social Security Number:

Street Address:

City, State, Zip Code:

Eligibility Date:

Contribution Date:

Single or Family Coverage?

HRA Annual Benefit Amount:

Authorization and Acknowledgement: I certify the above information to be true to the best of my knowledge.

Employer Signature:

Position

☐ **HRA Notice of Termination**

Date of Termination:

Employee Name:

Employer Signature:

Position