



- Newly Eligible
- Open Enrollment
- Tobacco Free Release
- Change of Status - appropriate documentation must be attached
- Rehire/ Rehire Date \_\_\_\_\_
- Beneficiary Change
- Spousal Surcharge Release

Employee ID#: \_\_\_\_\_

### 2014 Benefit Election Form

Employee: Please PRINT, sign and date application.

Social Security Number		Last Name		First Name		M.I.	Date of Birth
Street Address				City		ST	Zip Code
Home Telephone Number ( ) ( )		Work Telephone Number ( ) ( )		Date of Hire		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Location Name		Loc. State	Pay Group #	Effective Date	<input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Exempt (Group 2)		
Job Title		<input type="checkbox"/> Grade 11 & Below <input type="checkbox"/> Grade 12 - 19 <input type="checkbox"/> Grade 20 - 44 <input type="checkbox"/> Grade 45 - 59 <input type="checkbox"/> Grade 60 - 64 <input type="checkbox"/> Grade 65 +		Comments (list change of status if applicable)			

**ALL BENEFITS LISTED BELOW APPLY TO FULL TIME EMPLOYEES ONLY UNLESS OTHERWISE INDICATED**

<b>Modified Compensation – Non-Exempt only</b>		<input type="checkbox"/> Elect <input type="checkbox"/> Waive				
<b>Medical Coverage</b> (Check appropriate box)		Emp Only	Emp & Child/Children	Emp & Spouse	Family	Waive
Standard PPO/OAP Medical Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max Value PPO/OAP Medical Plan (Aetna, Blue Cross or Cigna based on State in which you work – see back of form)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Directed High Deductible (CDHD) Medical Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With Health Savings Account (HSA) annual amt _____ - Must open a HSA account associated with the plan (available ONLY if electing the CDHD plan: See 2014 Benefits Guidebook for details)						

The following 2 questions (if applicable) must be answered in order to be enrolled in any of our Medical Plans.

Do you or any of your dependents covered under our Medical Plan use tobacco products?  No  Yes (See Tobacco Free Reward on back of form)

Is your spouse/domestic partner employed full-time and eligible for medical benefits under his/her employer’s plan, but has elected to enroll only in the Genesis HealthCare medical plan? (See Spousal Charge on back of form)  No  Yes

<b>Dental Coverage</b> (Check appropriate box) (FT & PT)		Emp Only	Emp & Child/Children	Emp & Spouse	Family	Waive
Cigna Participating PPO Plan		<input type="checkbox"/>				
Cigna Non-Participating PPO Plan		<input type="checkbox"/>				
Cigna Managed Dental Plan Provider # _____ (refer to back of form) (6-digit #)		<input type="checkbox"/>				

<b>Vision Coverage</b> (Check appropriate box) (FT & PT)		Emp Only	Emp & Child/Children	Emp & Spouse	Family	Waive
Vision Service Plan (VSP)		<input type="checkbox"/>				

<b>Dependent Information – Attach eligibility documents (see back of form)</b>				<b>Current Patient?</b>	
<b>Spouse/DP</b>	Last Name, First, MI	Social Security Number	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dental Provider # (Managed Dental Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth			
<b>Child</b>	Last Name, First, MI	Social Security Number	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dental Provider # (Managed Dental Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth			
<b>Child</b>	Last Name, First, MI	Social Security Number	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dental Provider # (Managed Dental Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth			
<b>Child</b>	Last Name, First, MI	Social Security Number	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Dental Provider # (Managed Dental Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth			

**Pre-Tax Spending Accounts (do not need to meet with an Aflac Rep to enroll)**  
 Medical Flexible Spending Account (annually): \_\_\_\_\_ Dependent Care Spending Account\* (annually): \_\_\_\_\_  
 Waive Medical FSA  Waive Dependent Care FSA

**Aflac Products: (except Pre-Tax Spending Accounts) Voluntary Disability, Personal Accident Expense, Critical Event and Hospital Confinement**  
Must see the Aflac Representative within 30 days of eligibility for: Plan specifics, premium calculation, or to ENROLL, CHANGE or CANCEL coverage.

**Voluntary Supplemental Term Life Insurance**  Waive Voluntary Supplemental Life Insurance  
Must complete enrollment form within 30 days of eligibility to ENROLL, CHANGE or CANCEL coverage

<b>Group Life Insurance Beneficiary Information</b>	
<b>Primary Beneficiary</b>	<b>Secondary Beneficiary</b>
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone _____	Phone _____
Relationship to Employee _____	Relationship to Employee _____

**Employee Authorization**  
 AGREEMENT: I hereby authorize Genesis HealthCare to deduct, on a pre-tax basis (unless I have notified the Benefit Services Department otherwise), from my wages the necessary contributions for the benefits selected. I also understand that I must complete this election form within **30 days** of my benefit effective date. If not done within **30 days**, I must wait until the annual Open Enrollment. I may only terminate or change my coverage selection at the annual Open Enrollment unless my family status changes. If I do experience a family status change, I understand that changes to my benefits must be made within **30 days** of the event. I have also read the back of this form and understand its content. **If I elect insurance benefits, I will verify that my first pay following the effective date for my benefits has the appropriate deductions taken from my pay. If not, I will immediately notify my Benefits Designee.**  
 VERIFICATION: All statements and information indicated above are true and complete to the best of my knowledge and belief. I understand that any falsification of the statements above may result in the loss of benefits for myself and family, and will subject me to the Company’s disciplinary process (up to and including termination of employment).

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

## Important Notes – 2014

### Benefit Effective Dates (waiting periods and other Medical plan information):

- Group 1: Benefits begin after a 90 day waiting period for non-exempt (hourly) employees in Grades 1-19 excluding non-exempt employees categorized as 15X through 19X.
- Group 2: Benefits begin on the first of the month following date of hire for exempt (salaried) employees in Grades 20 and above, and non-exempt employees categorized as 15X through 19X.
- Administrator for Standard and Max Value plans is based upon the state in which you work: Aetna used for AZ, CA, CO, CT, FL, GA, KS, KY, ME, NJ, NV, NY, OH, OK, OR and WA. Cigna used for AR, MD, NH, TN, UT and VT. Blue Cross used for all other states.

### Eligible Dependents under Health Plans:

Employees may cover the following dependents only:

- Spouse/Domestic Partner (see required documentation that follows)
- Child/Children, \*less than 26 years of age
- Child/Children over the age of 26:
  - if child is incapable of self-support because of physical or mental incapacitation and is dependent for over half of their support upon the employee.

\*The term "children" will include children born of the employee, legally adopted by the employee, those children for whom employee has legal custody, and step-children or children of your domestic partner.

### All required documentation must include date and/or year, employee name and dependent's name.

- If you are enrolling children, or spouse/domestic partner, please submit appropriate documentation below:
- If you are enrolling a child over the age of 26 who is mentally or physically incapacitated, medical documentation is required. Continuation of benefits under this provision will only apply if child was covered under your prior medical plan. Please attach proof of previous coverage.

### For Legal Spouse or Common Law Spouse: Provide two forms of documentation from the list below.

1. Marriage License or Marriage Certificate or Common Law Affidavit
2. Front page of latest filed federal income tax return (please block out income information)
3. Document dated within past 6 months establishing current relationship (e.g., joint bank/credit account statement, joint mortgage/lease)

### For Domestic or Civil Union Partner: Provide documentation listed below.

1. Genesis Domestic Partner Affidavit with back up documentation.

### For Children: Provide one of the following items.

1. Birth Certificate with parents' names
2. Appropriate court order/adoption decree
3. Copy of divorce decree granting full or joint custody
4. Copy of QMCSO or other court order where employee is required to provide health care coverage

### Modified Compensation:

Election of Modified Comp, the "No Benefit" Program, means that an employee's time off benefits (vacation, sick and holiday time) and certain benefits including medical, company paid life insurance, short term disability and flexible spending accounts (FSA) are converted into direct compensation. These benefits are "**traded**" in exchange for an increase to the employee's base pay rate. If eligible to change from Benefits to Modified Comp during the year or at Open Enrollment, upon the effective date of the election of Modified Comp, **any unused personal days, accrued/available vacation, and/or sick time is normally forfeited.** Please see the Benefits Guidebook or your Manager for more details.

### Tobacco Free Reward (Living Well Program)

Research has verified that people who use tobacco products, and most likely those people living with smokers, are at greater risk for illness and, therefore, spend more health care dollars which results in higher premiums. Genesis charges those employees who do not use tobacco products \$40.00 bi-weekly or \$20.00 weekly **less** in premiums than employees and/or their dependents who are currently using tobacco products and are participating in our medical plans. If you have answered "yes" to the question "Do you or any dependents covered under our medical plan use tobacco products?" the Tobacco Free Reward does **not** apply. **This question must be answered in order to be eligible to enroll in the health plans.**

Genesis is committed to helping you achieve your best health. Rewards for participating in the Genesis Living Well programs are available to all eligible employees. If you think you might be unable to meet a standard for a reward under our wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Living Well mailbox at [livingwell@genesishcc.com](mailto:livingwell@genesishcc.com) and we will work with you and, if you wish, your doctor, to find a wellness program with the same reward that is right for you in light of your health status.

### Spousal Charge:

Employees whose spouse/domestic partner has access to health insurance from his/her own employer, but who chooses to enroll only in the Genesis HealthCare plan will incur a \$50.00 bi-weekly or \$25.00 weekly premium surcharge.

If you answered "yes" to the question, "Is your spouse/domestic partner employed full-time and eligible for medical benefits under his/her employer's plan, but has elected to enroll only in the Genesis HealthCare medical plan?" this additional charge will be applied. **This question must be answered in order to enroll your spouse/domestic partner in the medical plans.**

Situations where the surcharge will not apply are if the spouse/domestic partner:

- is enrolled in both his/her plan and the Genesis medical plan; or
- is employed part-time; or
- self-employed without coverage

If your spouse/domestic partner elects medical coverage from his/her employer during our plan year, you can drop coverage under the Genesis plan (family status change) and/or request to have the surcharge removed.

Documentation of your spouse/domestic partner's benefit eligibility will not be required except for mid-year status changes. However, Genesis reserves the right to conduct random audits to collect documentation from spouse/domestic partners that are enrolled in a Genesis HealthCare sponsored medical plan and have waived the spouse/domestic partner surcharge.

### Cigna Managed Dental:

This plan requires that you select a participating dental provider in order to be enrolled. Failure to provide a "Valid" Primary Care Dentist (PCD) number will prevent you from obtaining services. Please contact your dental care provider to confirm that they are a participating provider with the Cigna Managed plan and obtain their six-digit provider code; or contact Cigna to find out how to obtain a list of providers within your zip code.

### Pre-Tax Spending Accounts:

The Plan year for both the Medical and Dependent Care Pre-Tax Spending Accounts begins January 1st (or eligibility date if later) and ends December 31st. When estimating expenses for the year, please keep in mind that any unused money left in your account at the end of the Plan year or date of your termination/cancellation due to family status change may be forfeited; however, you will have an additional period of time (until April 15th) after the end of the Plan year to submit receipts for reimbursement of services received during the Plan year or eligible period. Please refer to the Benefits Guidebook and/or Central for more details.

Please do not include any amounts for medical, dental or vision plan premiums. Due to IRS rulings, these premiums are not eligible for reimbursement under the Genesis Pre-Tax Spending Account Program as they are already deducted on a pre-tax basis.

### Benefit Deductions:

Initial premium deductions or those needed as a result of a change in status are taken in the first pay period in which the benefit effective date falls.