# BELL CONCRETE / LAMAR COMPANIES

## ENROLLMLENT FORM

**December 1, 2022 – November 30, 2023**

**Address Change___**

Last Name:_____First Name:_____Gender:_____

Social Security Number: _____ Date of Birth: _____ Date of Hire: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Salary:_____ Occupation: _____

**HEALTH INSURANCE: Assured Benefits Administrators**
**United Healthcare Network**

**Check here if you are Waiving Coverage_☐___**

PER PAY PERIOD DEDUCTION (WEEKLY):

Employee Only $0_☐___ Employee + Spouse $179.59_☐___

Employee + Child(ren) $97.86_☐___ Employee + Family $259.05_☐___

**VOLUNTARY DENTAL: Mutual of Omaha**

**Check here if you are Waiving Coverage_☐__**

PER PAY PERIOD DEDUCTION:

Emp. Only $7.11_☐__Emp. + Spouse $14.49_☐__Emp. + Child(ren) $13.83_☐__Emp. + Family $22.18_☐__

**VOLUNTARY VISION INSURANCE: Superior Vision**

**Check here if you are Waiving Coverage_☐__**

PER PAY PERIOD DEDUCTION:

Emp. Only $1.67_☐__Emp. + Spouse $3.34_☐__Emp. + Child(ren) $3.82_☐__Emp. + Family $5.89_☐__

**BASIC LIFE/AD&D: Mutual of Omaha**

Life/AD&D Insurance is provided by Bell Concrete/Lamar Companies, LLC. to each employee in the amount of $20,000. There is no cost to the employee for this benefit.

Beneficiary Name:_____DOB:_____ Relationship:_____Percentage: ____

Contingent Beneficiary Name:_____DOB:_____Relationship:_____Percentage:____

**Do you want *additional* LIFE/ AD&D: Mutual of Omaha**

**Accept:_☐__or Decline: _☐__**

Voluntary Life/AD&D Insurance is offered by Lamar Companies, LLC. to employees and their dependents. Please see your Human Resource Director for benefit information and rates. **You must complete a Mutual of Omaha Enrollment Form to enroll in the Voluntary Life/AD&D.**

**VOLUNTARY SHORT-TERM DISABILITY: Mutual of Omaha**

PER PAY PERIOD DEDUCTION: SEE RATE CHART IN GUIDE

**Accept:_☐__or Decline:_☐__**
**Deduction amount_____**

☐ ☐

**VOLUNTARY ACCIDENT : Mutual of Omaha**
PER PAY PERIOD DEDUCTION:

**Check here if you are Waiving Coverage** ☐

Emp. Only $2.39 ☐ Emp. + Spouse $3.47 ☐ Emp. + Child(ren) $5.13 ☐ Emp. + Family $6.57 ☐

**VOLUNTARY CRITICAL ILLNESS: Mutual of Omaha**
PER PAY PERIOD DEDUCTION: SEE RATE CHART IN GUIDE

**Accept:** ☐ **or Decline:** ☐
**Deduction amount**_____

**If electing dependents for medical, dental/vision, please provide the following:**

Spouse Name:_____ Date of Birth:_____ SS#:_____ Gender: _____

Dependent Name:_____ Date of Birth:_____ SS#:_____ Gender: _____

Dependent Name:_____ Date of Birth:_____ SS#:_____ Gender: _____

Dependent Name:_____ Date of Birth:_____ SS#:_____ Gender: _____

Dependent Name:_____ Date of Birth:_____ SS#:_____ Gender:_____

Employee Signature_____ Date _____

# LEVEL FUNDED HEALTH PLAN
# EMPLOYEE ENROLLMENT FORM

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Assured Benefits Administrators

***Email the completed and signed form to eligibility@abadmin.com.***

*Administrative Use Only*

CASE # _____
EMPLOYEE # _____
CLASS _____
EFFECTIVE DATE _____

OCC ☐ YES ☐ NO
UWF 48 ☐ YES ☐ NO DATE _____
UWF 40 ☐ YES ☐ NO
HEALTH ☐ YES ☐ NO

## SECTION 1 EMPLOYEE INFORMATION

FIRST NAME _____ M.I. _____ LAST NAME _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED OR WIDOWED

RESIDENTIAL ADDRESS _____

CITY _____ STATE _____ ZIP _____ GENDER ☐ MALE ☐ FEMALE

DOB (MM/DD/YY) _____ HEIGHT (FT'IN") _____ WEIGHT (LBS) _____

PHONE NUMBER _____ BEST TIME TO CONTACT _____ EMAIL _____

SSN _____ GROUP NUMBER _____ LOCATION _____

EMPLOYER _____ FULL TIME START DATE _____ AVG. WEEKLY HOURS _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE _____ ARE YOU AN OWNER, PARTNER OR CORPORATE OFFICER? ☐ YES ☐ NO

OCCUPATION AND DUTIES _____

I AM ENROLLING FOR (CHECK ONE): ☐ SELF ONLY ☐ SELF & SPOUSE ☐ SELF & CHILD(REN) ☐ SELF, SPOUSE & CHILD(REN)

**I AM WAIVING COVERAGE FOR** ☐ SELF (AND DEPENDENTS) ☐ SPOUSE ☐ DEPENDENT CHILDREN

*If waiving coverage,* I AM WAIVING MY COVERAGE AND **NOT** ENROLLING BECAUSE:

☐ COVERED BY AN ABA MEC PLAN ☐ COVERED BY ANOTHER PLAN ☐ OTHER (EXPLAIN): _____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the plan, provided that I request enrollment within 30 days after my other coverage ends because of involuntary loss of other coverage (i.e. divorce, death, legal separation, termination of employment, reduction in number of hours of employment, termination of employer contributions toward the other coverage, any loss of eligibility, change of residency or place of work to outside the service area and no other benefit package is available, cessation of dependent status, or plan no longer offers benefits to the class of similarly situated individuals that includes the individual). In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 30 days after the date of the event.

NAME _____ DATE _____ SIGNATURE _____

## PARTICIPANT INFORMATION Complete for each person to be enrolled.

| | PARTICIPANT NAME | RELATIONSHIP | GENDER | HEIGHT | WEIGHT | DATE OF BIRTH | SOCIAL SECURITY NUMBER | TOBACCO USE |
|---|---|---|---|---|---|---|---|---|
| 1 | | SELF | | | | | | ☐ YES ☐ NO |
| 2 | | | | | | | | ☐ YES ☐ NO |
| 3 | | | | | | | | ☐ YES ☐ NO |
| 4 | | | | | | | | ☐ YES ☐ NO |
| 5 | | | | | | | | ☐ YES ☐ NO |

*Use a separate sheet if additional space is needed, and sign and attach additional pages.*

# LEVEL FUNDED HEALTH PLAN
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## SECTION 2 **PRIOR COVERAGE CREDIT**

**DO YOU OR YOUR DEPENDENTS CURRENTLY HAVE ANY OTHER HEALTH INSURANCE COVERAGE?** ☐ YES ☐ NO

*If **YES**, provide the following information on **all** coverage in force in **the past 12 months**. Most of this information can be obtained from your current benefit plan identification card.*

**COVERAGE TYPE** ☐ COMPREHENSIVE MAJOR MEDICAL ☐ OTHER (PROVIDE COPY OF BENEFIT PLAN OR SCHEDULE OF BENEFITS)

**NAME OF PLAN** _____ **PHONE NUMBER** _____ **EFFECTIVE DATE** _____

**TERMINATION DATE** _____ **REASON FOR TERMINATION** _____

**PLAN TYPE** ☐ EMPLOYER SPONSORED: EMPLOYER NAME _____ POLICY/CERT. # _____

☐ INDIVIDUAL: POLICY/CERT. # _____

**COVERAGE WAS FOR:** (CHECK ONE) ☐ SELF ONLY ☐ SELF & SPOUSE ☐ SELF & CHILD(REN) ☐ SELF, SPOUSE & CHILD(REN)

*Proof of coverage is required if prior coverage is any health plan other than your current employer's plan. Please provide us with a copy of your Certificate of Creditable Coverage provided by the health plan or other suitable documentation. If coverage for self or a dependent is from a different source please document on a separate sheet of paper and attach.*

## SECTION 3 **MEDICAL INFORMATION**

IN THE PAST FIVE YEARS, HAVE YOU OR ANYONE ENROLLING FOR COVERAGE HAD A **DIAGNOSIS** OF OR **CONSULTATION, TREATMENT OR MEDICATION** FOR:

| | | | | | |
|---|---|---|---|---|---|
| BRAIN OR NERVOUS SYSTEM DISORDER | ☐ YES | ☐ NO | DIABETES OR SUGAR IN URINE | ☐ YES | ☐ NO |
| ENDOCRINE OR ADRENAL DISORDER | ☐ YES | ☐ NO | DIGESTIVE OR GASTROINTESTINAL DISORDER | ☐ YES | ☐ NO |
| LIVER, PANCREAS OR KIDNEY DISORDER | ☐ YES | ☐ NO | BREAST OR REPRODUCTIVE ORGAN DISORDER | ☐ YES | ☐ NO |
| ABNORMAL BLOOD PRESSURE | ☐ YES | ☐ NO | AUTOIMMUNE DISORDER | ☐ YES | ☐ NO |
| HEART OR CIRCULATORY SYSTEM DISORDER | ☐ YES | ☐ NO | BACK OR SPINE DISORDER | ☐ YES | ☐ NO |
| CHEST PAIN OR STROKE | ☐ YES | ☐ NO | RHEUMATOID ARTHRITIS | ☐ YES | ☐ NO |
| BLOOD DISORDER | ☐ YES | ☐ NO | MULTIPLE SCLEROSIS OR CYSTIC FIBROSIS | ☐ YES | ☐ NO |
| LYMPHATIC VESSEL OR GLAND DISORDER | ☐ YES | ☐ NO | SKIN OR COLLAGEN DISEASE | ☐ YES | ☐ NO |
| CIRRHOSIS OR HEPATITIS | ☐ YES | ☐ NO | MUSCLE DISEASE | ☐ YES | ☐ NO |
| LEUKEMIA OR HODGKIN'S DISEASE | ☐ YES | ☐ NO | EMPHYSEMA, TUBERCULOSIS OR CHRONIC OBSTRUCTIVE PULMONARY DISEASE | ☐ YES | ☐ NO |
| CANCER (EXCLUDING BASAL CELL CARCINOMA) | ☐ YES | ☐ NO | | | |

Are you or any dependents (whether enrolling for coverage or not) currently pregnant? ☐ YES ☐ NO

*If yes:* **DUE DATE** _____ **ANTICIPATED C-SECTION** ☐ YES ☐ NO **EXPECTING MULTIPLE BIRTHS** ☐ YES ☐ NO

**EXPERIENCING AND/OR ANTICIPATING ANY OTHER COMPLICATIONS** ☐ YES ☐ NO

Within the last five years, has anyone enrolling for coverage been diagnosed with or treated for human immunodeficiency virus (HIV) infection; any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition; significant weight loss; or chronic fatigue, diarrhea, night sweats or enlarged glands? ☐ YES ☐ NO

*Continued on the next page.*

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## SECTION 3 **MEDICAL INFORMATION** (Continued)

Has anyone enrolling visited a doctor, had a medical consultation or surgery, or been hospitalized in the past five years? ☐ YES ☐ NO

Are you or any dependents (whether enrolling for coverage or not) anticipating surgery, or is anyone enrolling for coverage disabled, restricted or unable to perform the normal activities of daily living and self care? ☐ YES ☐ NO

Are you or any dependents enrolling for coverage currently taking medication? ☐ YES ☐ NO

For anyone enrolling for coverage, is there any existing medical condition or problem (including any undiagnosed symptoms) that has not otherwise been disclosed on this enrollment form? ☐ YES ☐ NO

*If you answered **YES** to **any** of the questions in **SECTION 3, MEDICAL INFORMATION**, provide details below. Use a separate sheet if additional space is needed, and sign and attach additional pages. If taking medication for blood pressure, include your last three blood pressure readings.*

| NAME OF PERSON WITH CONDITION OR TREATMENT | CONDITION OR TREATMENT REASON | DATES OF TREATMENT | MEDICATIONS & DOSAGES | RECOVERY STATUS | LIST ANY TREATMENT, SURGERY OR ANTICIPATED SURGERY FOR THIS CONDITION |
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# EMPLOYEE ENROLLMENT FORM

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## SECTION 4 **EMPLOYEE STATEMENT AND SIGNATURE**

**I HEREBY**: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

**I FURTHER ACKNOWLEDGE AND UNDERSTAND**: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed, or an 18-month Pre-Existing Condition Limitation Period may apply; A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; Assured Benefits Administrators is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

**SPECIAL ENROLLMENT RIGHTS**: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer.

**PERSONAL INFORMATION NOTICE**: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

**AUTHORIZATION FOR RELEASE OF INFORMATION**: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re- disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

SIGNATURE

PRINT NAME

DATE

*Electronic copies of this enrollment form submitted via fax, email or other electronic means shall be deemed an original.*