

MEC PLAN MEDICAL ENROLLMENT/CHANGE FORM

WINCO MASONRY, LP

Group # H870767

Please Print. Add additional pages as needed

Complete All Areas

TO BE COMPLETED BY HUMAN RESOURCES:	Effective Date: _____ Hire Date: _____
	Imagine360 Div #: <input type="checkbox"/> WIN - WINCO <input type="checkbox"/> HMI - RANKIN <input type="checkbox"/> WMB - BUILDERS <input type="checkbox"/> 999 - COBRA

This form must be completed and returned to Human Resources within 31 days of the following events:

- Open Enrollment
- Your benefits effective date
- The date you experience a qualifying event

CHECK ALL THAT APPLY

<input type="checkbox"/> New Enrollment _____ Date	<input type="checkbox"/> Name Change _____ Date	<input type="checkbox"/> Add/Delete Dep _____ Date
<input checked="" type="checkbox"/> Open Enrollment <u>01/01/2025</u> Date	<input type="checkbox"/> Address Change _____ Date	<input type="checkbox"/> Termination _____ Date
<input type="checkbox"/> Special Enrollment _____ Date	<input type="checkbox"/> Marriage _____ Date	<input type="checkbox"/> Divorce _____ Date

Social Security #:	Last Name:	First Name:	Middle Initial:

Mailing Address:	City:	State:	Zip Code:

<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Marital Status:	Employee Phone Numbers: Home: () Cell: ()
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	

Medical Coverage Election: Employee Only Employee + Child Employee + Child(ren)

Circle (A) Add, (D) Delete or (W) Waive	DEPENDENT INFORMATION (Complete only if enrolling dependents - children eligible to age 26) LAST NAME, FIRST NAME	Relationship (i.e., spouse, natural child, stepchild, legal guardianship, etc.)	Date of Birth	Gender M/F	Dependent Social Security Number
A / D / W					
A / D / W					
A / D / W					
A / D / W					
A / D / W					
A / D / W					

- Are your Dependent Child(ren) listed above your biological child, stepchild or adopted child? Yes No If no, please answer the questions A-D below for the child(ren) that do not meet the relationships stated above:
 - Please list the child's name and your relationship with the child: _____
 - Does this child live with you? Yes No
 - Do you have legal guardianship or conservatorship for this child? Yes No
 - Will you provide more than six months of support & claim this child on your Federal Income Tax Return this year? Yes No
- Are you or your dependents covered under other group health coverage? Yes No If yes, provide name of other insurance company, name of insured person(s), and policy/group number: _____
- Do you or any of your Dependents have Medicare? Yes No If yes, provide name of Insured person: _____ Effective date: _____ and Medicare number (from Medicare Card) _____

WAIVER OF COVERAGE (HIPAA provision may impact your eligibility to re-enter your health plan)
Although I (and my eligible Dependents) have been given the opportunity to enroll in the Benefit Plan offered by my Employer, I decline to enroll
 Self
 Dependent(s) listed by name _____
 I have other coverage My dependents have other coverage Do not choose to make contribution Other _____

Signature of Employee: _____ **Date:** _____

ACCEPTANCE OF COVERAGE STATEMENT
I have read and understand the Enrollment disclosure and accept this Agreement.
Signature of Employee: _____ **Date:** _____
I agree my contributions will be withheld by my employer on a pre-tax basis and I acknowledge I cannot change my election during the Plan Year unless there is a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of child, termination of spouse's employment). Election Changes must be made within 31 days after the qualifying event.