BENEFITS ENROLLMENT

BRING HEALTH BENEFITS ENROLLMENT FORM AND REQUIRED DOCUMENTATION, SUPPLEMENTAL LIFE ENROLLMENT FORM (IF APPLYING), TASC ENROLLMENT FORM (IF APPLYING) TO DELTA POINT HR. ELECTIONS WILL PROCESSED AS WAIVED IF NOT RECEIVED BY THE DAY PRIOR TO THE EFFECTIVE DATE.

REQUIRED DOCUMENTATION:

EMPLOYEE:

____ COPY OF SOCIAL SECURITY CARD

SPOUSE (if adding to health/life):

____ CERTIFIED MARRIAGE CERTIFICATE

____COPY OF SOCIAL SECURITY CARD

____ SELF FUNDED ONLY – SPOUSAL INQUIRY/COB FORM AND BACKUP

____EPO PLAN – COB FORM

CHILDREN (If adding to health/life):

____COPY OF BIRTH CERTIFICATE

____COPY OF SOCIAL SECUIRTY CARD

____ SELF FUNDED ONLY – SPOUSAL INQUIRY/COB FORM AND BACKUP

____EPO PLAN – COB FORM

IF SUPPORTING DOCUMENTATION IS NOT SUBMITTED WE CANNOT ACCEPT YOUR PAPERWORK AND BENEFITS ENROLLMENT MAY BE DELAYED. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

New Hire Quick Facts Sheet

Completion of Benefits Enrollment Form – Benefits are effective 1st of the month following 15 days of employment

- Elect between CC EPO and CCSF PPO
- Complete "Participation Information"
- Health Plan Choices
  - Clark County Self-Funded Group Medical and Dental Benefits Plan (PPO)
  - Clark County Exclusive Provider Organization (EPO)
  - I Decline/Waive All Coverage for Myself and My Dependents
- Personal Identification No. = PRNR (Employee #)
- Under "Family Information" list all dependents, if any (you don't need to list yourself)
- Basic Life Insurance Beneficiary Designation – Complete even if you're waiving healthcare benefits
  - UMC provides a free $20,000 Basic Life Insurance to all benefited employees
- Post-Tax election – Check only if you want to pay your healthcare premium with post-tax monies
- Sign and date the form
- Both plans provide coverage for Medical, Dental, Vision and Prescription

Two Plans Available

- Clark County Self-Fund PPO Plan (CCSF)
  - Plan administrator is UMR
  - PPO network is Sierra Healthcare Options (SHO)
  - $250.00 calendar year deductible per person / $750.00 per family for major services like in-patient admission and surgical procedures for PPO providers
  - $3,750.00 out of pocket maximum per person / $7,750.00 per family for PPO providers
  - Out of network benefits available, paid at 60% of plan allowable
  - Spousal penalty applies – See Spousal Inquiry COB Form, included in this packet
  - See link below for a Summary of Benefits and Coverage (SBC) of the plan https://umcintranet/hr/HRDocuments/OpenEnrollment/2022/2022%20CCSF%20Summary%20of%20Benefits%20and%20Coverage.PDF

- Clark County Exclusive Provider Organization Plan (EPO)
  - Plan administrator is UMR
  - PPO Network is Sierra Healthcare Options (SHO)
  - No calendar year deductible
  - All Co-Pays
  - $3,750.00 out of pocket maximum per person / $7,750.00 per family for PPO providers
  - No out of network benefits
  - Spousal penalty does not apply – See COB form
  - See link below for a Summary of Benefits and Coverage (SBC) https://umcintranet/hr/HRDocuments/OpenEnrollment/2022/2022%20EPO%20Summary%20of%20Benefits%20and%20Coverage.pdf

CCSF Spousal Inquiry /Coordination of Benefits (COB) Form – Page 1

- Complete only if you are electing the CCSF PPO plan
- Member ID = PRNR (Employee #)
- Answer all applicable questions, 1 – 9 regarding spouse
- If spouse is employed and they have access to their own insurance they must sign up for their own benefits otherwise a penalty will apply (reimbursement rate = 20% and no prescription coverage). The only way to avoid the penalty is if the spouse's employer does not offer a Non-HMO plan for under $105.00 dollars. A rate sheet from the spouse's employer is required to confirm.
- If spouse's employer does not offer healthcare benefits or the spouse is ineligible for benefits a note on company letterhead from the spouse's employer is required.
- Sign and date form

CCSF Spousal Inquiry /Coordination of Benefits (COB) Form – Page 2

- Answer all applicable questions, 1 – 2 regarding dependents
- If any dependent is covered by Medicare provide all Medicare information
- If any dependent is covered by another healthcare plan provide all information (ID#, Group#.....)
- For children of divorced parents – provide copy of the divorce decree – Need this to determine which plan is primary on children.
- Sign and date form

EPO Coordination of Benefits (COB) Form

- Complete only if you're electing the EPO plan
- Member ID – PRNR (Employee #)
- Answer all applicable questions, 1 – 2 regarding dependents
- If any dependent is covered by another healthcare plan provide all information (ID#, Group#.....)
- For children of divorced parents – provide copy of the divorce decree – Need this to determine which plan is primary on children.
- If any dependent is covered by Medicare provide all Medicare information
- Sign and date form

Sun Life Financial Group Enrollment Form – COMPLETE ONLY IF YOU WISH TO ENROLL IN SUPPLEMENAL LIFE INSURCE OR AD&D INSURANCE (in addition to the free Basic Life Insurance that UMC provides)

- Start with Bullet #2 – Employee Information
- Voluntary Life Coverage
  - Coverage Amount Elected – Provide coverage amount, for example $250,000
  - During the new hire process you may enroll onto a $250,000 plan no questions asked
  - If waived your next opportunity will be during Open Enrollment and Evidence of Insurability will be required regardless of the coverage amount elected
- Family Voluntary AD&D Coverage
  - Only one election is allowed – Choose between an Employee Election or a Family Election
  - Coverage Amount Elected – Provide coverage amount, for example $300,000
- Dependent Information – Complete as applicable
  - Children 26 years of age or older are not considered eligible dependents

- Primary Beneficiary Designation
  - Voluntary Life Insurance
    - Split percentages must total 100%
    - Only whole numbers
    - You can add additional beneficiaries by making copies of page 3 or list them on a separate sheet
  - Voluntary AD&D Insurance
    - Must duplicate beneficiary information if using the same individuals as for Voluntary Life Insurance
    - Split percentages must total 100%
    - Only whole numbers
    - You can add additional beneficiaries by making copies of page 3 or list them on a separate sheet
- Secondary Beneficiary Designation
  - Voluntary Life Insurance
    - Split percentages must total 100%
    - Only whole numbers
    - You can add additional beneficiaries by making copies of page 3 or list them on a separate sheet
  - Voluntary AD&D Insurance
    - Must duplicate beneficiary information if using the same individuals as for Voluntary Life Insurance
    - Split percentages must total 100%
    - Only whole numbers
    - You can add additional beneficiaries by making copies of page 3 or list them on a separate sheet
- Guaranteed Issue Amounts (No Questions Asked)
  - Employee - $250,000.00
  - Spouse - $30,000.00
  - Enrollment onto anything over these amounts requires Evidence of Insurability
- Sign and date form

Supplemental Life Insurance Rate Sheet

- Locate Face Amount Column (Coverage Amount)
- Go down and identify the desired coverage amount
- Go across and locate your applicable age bracket
- The corresponding amount is the monthly premium (divide by 2 and this will be your per pay period deduction)
- For example the cost for a 30 year old employee to purchase a $250,000 is $20.00 ($10.00 per pay period)

TASC – Flexible Spending Account (FSA) Enrollment Form

- PRNR = Employee number
- Complete Individual/Participant Information
- Annual Elections – Mark Applicable Box
  - Healthcare FSA
    - A pre-funded debit card equal to the election amount will be issued

        - Payroll will divide the election amount by 24 - this is the per pay period deduction
    - Dependent Care FSA
        - This a reimbursement account, funds must be accrued before a claim can be submitted
    - Enter election amount in Employee Annual Election Amount field for Healthcare FSA and/or Dependent Care FSA
- TASC Card
    - Provide information if additional debit cards are needed
- Sign and Date Form

Voluntary Benefits by Guardian and Trustmark

- Make appointment at www.myclarkcountybenefits.com
- A licensed agent will call you and go over the plans and fee
- If you decide to enroll UMC will be notified

____ New Employee
____ Retiree
____ Surviving Spouse / Dependent

CLARK COUNTY, NEVADA AND AFFILIATES BENEFITS ENROLLMENT FORM

___ Qualified Life Event (QLE)
___ Open Enrollment Change

For HR Use

CCSF PPO _____ CC EPO_____

EFFECTIVE DATE: _____

ENTITY:

****2024****
OPEN ENROLLMENT

_____ Clark County
_____ Henderson Library
_____ LVMPD -Appointed
_____ Las Vegas Convention & Visitor's Authority
_____ Las Vegas Valley Water District
_____ Mt. Charleston Fire
_____ Moapa Valley Fire District
_____ Regional Flood
_____ RTC
_____ So. Nev. Health District
__X__ University Medical Center
_____ Water Reclamation District

PARTICIPANT INFORMATION

NAME, LAST	FIRST	M.I.	PERSONAL IDENTIFICATION NO.	BIRTH DATE	SEX ❑ FEMALE ❑ MALE
MAILING ADDRESS				HOME PHONE	
CITY		STATE	ZIP	WORK PHONE	
DEPARTMENT			HIRE DATE	CELL PHONE	

PERSONAL E-MAIL ADDRESS: _____ **WORK E-MAIL ADDRESS**: _____

HEALTH PLAN CHOICES

❑ Clark County Self-Funded Group Medical and Dental Benefits Plan (PPO)
❑ Clark County Exclusive Provider Organization (EPO)
❑ I Decline / Waive All Coverage for Myself and My Dependents – Reason: _____
❑ I Decline/Waive Dental and/or Vision ___ Coverage for Myself and My Dependents Reason: _____

I choose coverage for: ❑ Participant Only ❑ Participant *plus* Spouse ❑ Participant *plus* Child(ren) ❑ Participant *plus* Family Spouse & Child(ren)

FAMILY INFORMATION: Use additional page if needed, be sure to sign and date. Please list all eligible family members to be enrolled. A copy of your marriage certificate and social security card are required when adding a spouse. A copy of your child(ren)'s birth certificate(s) and social security card(s) are a requirement when electing coverage for child(ren).

NAME	SEX	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER

Basic life insurance is automatically provided to each eligible employee or retiree. When a retiree reaches age 70 the amount of coverage decreases. Dependents covered under the medical coverage are also covered under the basic life insurance in lesser amounts. Employees may also apply for supplemental life insurance coverage. **Participation in the supplemental life program requires a completion of a separate enrollment form.**

Basic Life Insurance Beneficiary Designation

Primary Beneficiary	**Contingent Beneficiary**
Name _____	Name _____
Mailing Address _____	Mailing Address _____
_____	_____
Relationship _____	Relationship _____

PARTICIPANT CERTIFICATION

I certify under penalty of perjury that the above answers are true to the best of my knowledge. I am aware if I elect not to enroll myself or my eligible dependents at the time of initial eligibility that I may only enroll or add dependents as allowed under the terms and conditions of the Clark County employer sponsored health plans. I understand that benefits will be available subject to the exclusions, limitations and benefits described in the Clark County employer sponsored health plans. I acknowledge that I must notify my employer within 31 days of any change in dependent eligibility.
I hereby acknowledge and agree that all health insurance premiums will be deducted on a pre-tax basis from my earnings for the coverage elected and that this election will remain in effect for the rest of the plan year unless I experience a Qualifying Event as defined.

❑ **I choose to have my contribution deducted on a post-tax basis**

Signature: _____ **Date:** _____

Risk Management Use
Coverage Effective Date: _____
Initials: _____

RETURN COMPLETED FORM TO RISK MANAGEMENT

REV. 09-6-2021

Group Health Insurance Rates

PER PAYCHECK

Two (2) paychecks per month only 24 payments per year

Effective: January 1, 2024

CLARK COUNTY SELF FUNDED	EMP. ONLY	EMP./SPOUSE	EMP./CHILD(REN)	EMP./FAMILY
.5 (20 hrs/week)	$101.93	$193.81	$183.10	$268.80
.6 (24 hrs/week)	$98.63	$187.41	$177.16	$259.70
.7 (28 hrs/week)	$95.31	$180.95	$171.22	$250.62
.8 or above (32+ hrs/week)	$12.50	$128.53	$120.30	$190.30
VISION – ONE PAYCHECK (1ST PP)	**EMP. ONLY**	**EMP./SPOUSE**	**EMP./CHILD(REN)**	**EMP./FAMILY**
.5 (20 hrs/week)	$0.24	$0.68	$0.49	$1.14
.6 (24 hrs/week)	$0.24	$0.68	$0.49	$1.14
.7 (28 hrs/week)	$0.24	$0.68	$0.49	$1.14
.8 or above (32+ hrs/week)	$0.00	$0.68	$0.49	$1.14

EXCLUSIVE PROVIDER ORG (EPO)	EMP. ONLY	EMP./SPOUSE	EMP./CHILD(REN)	EMP./FAMILY
.5 (20 hrs/week)	$106.03	$202.69	$189.77	$277.04
.6 (24 hrs/week)	$103.17	$196.98	$184.67	$269.38
.7 (28 hrs/week)	$100.29	$187.53	$178.78	$261.70
.8 or above (32+ hrs/week)	$12.46	$145.44	$135.57	$210.00

BASIC LIFE INSURANCE BENEFIT

(INCLUDED IN PREMIUM PAYMENTS LISTED ABOVE)

Employee	$20,000 **plus** $20,000 AD&D
Spouse	$5,000
Child (Age 6 months or more)	$2,500
Child (age 14 days to 6 months)	$1,000

Note: Dependents are covered under the basic life insurance policy ***only if*** the employee has covered the dependent under one of the health plans listed above.

Clark County
Exclusive Provider Organization

UMR

SELF-FUNDED GROUP MEDICAL and DENTAL BENEFITS PLAN
Clark County

IMPORTANT HEALTH INSURANCE INFORMATION - PLEASE SEND UPDATE BACK WITHIN 31 DAYS

Name:_____
Address:_____
Phone:_____
Member ID #:_____
GROUP: CLARK COUNTY

UMR is requesting up-to-date information regarding any additional health care coverage that you or your covered spouse or dependent children may have obtained. We must have your reply *annually* to avoid delays in the processing of claims.

Please fill out this questionnaire completely and return to UMR:

1) Is anyone in your family covered by another medical or dental plan? Yes ☐ No ☐
(Examples: A stepchild covered by a natural parent; a child covered by another parent through divorce decree; an adult dependent covered by his/her own employer or his or her spouse's employer, or continued coverage for a spouse after termination of employment.)

If yes, provide the following:

Dependent name_____Relationship_____
Dependent name_____Relationship_____
Dependent name_____Relationship_____
Dependent name_____Relationship _____

Name of Health Plan / Policy holder name, relationship and **Date of Birth**/ Member # / Group # / Effective date / Phone #

_____
_____
_____

Is there a divorce decree or legal documentation indicating who is to cover dependent? Yes ☐ No ☐
If yes, please submit a copy along with this completed notice.

2) Is anyone in your family covered by Medicare?

Part A Yes ☐ No ☐
Part B Yes ☐ No ☐
Part C Yes ☐ No ☐

List family members, if covered by Medicare _____

(Please note: If you are a Retiree and eligible for Medicare, you must maintain your Medicare B coverage for both retiree and dependents as penalties may apply)

Medicare ID Number and effective date: _____

What is the reason for Medicare Eligibility? Please check one – Age ☐ Disability ☐ ESRD ☐ Other _____

I certify and affirm that my dependents listed above is an eligible dependent pursuant to the provisions and requirements as outlined in the Clark County benefits Plan eligibility requirements and coordination of benefits. I attest under penalty of perjury this information is true to the best of my knowledge as of the date of my signature hereon and I further acknowledge that I must notify my employer within 31 days of any change in this eligibility or coverage.

I understand and acknowledge that in the event such information is untrue or inaccurate or I fail to remove a dependent from my chosen health plan within 31 days from the date that they no longer qualify as a dependent pursuant to the provisions and requirements of coverage, then this fraud may subject me to a variety of consequences including but not limited to, referral to the District Attorney's Office for criminal prosecution, restitution to the Plan for improperly medical/dental/pharmacy paid claims and premiums, referral to my employer for disciplinary action up to and including termination and termination of my health coverage.

Employee signature only:_____ Date:_____

Please return to UMR at PO Box 30541, Salt Lake City, UT 84130-0541. You may also E-Mail this notice to clarkcountycobupdate@umr.com or fax to UMR at 915-581-7537

Life Insurance Coverage

- University Medical Center provides at no cost to the employee Basic Life Insurance and Basic AD&D coverage in the amount of $20,000.00. Dependents, if covered on the health insurance, are also covered for Basic Life Insurance.
    - $20,000 – Employee
    - $5,000 – Spouse
    - $2,500 – Dependent Child(ren) (over 6 months)
    - $1,000 – Dependent Child(ren) (ages 14 days to 6 months)
- You also have available to you, on an individual basis, additional Supplemental Life Insurance and Accidental Death & Dismemberment Insurance (AD&D). Employees are responsible for the full cost of the premiums for this additional coverage.
- Guarantee issue amounts are available for Supplemental Life at the initial time of enrollment for health benefits.
    - $250,000 – Employee
    - $30,000 – Spouse
    - $20,000 – Child(ren)
- Any additional amounts over the Guarantee Issue limit are available, subject to the approval by the life insurance underwriter. Once the final determination of application has been made, University Medical Center Benefits will notify you in writing.

Please note: The information contained in this outline and the oral presentation is intended as a very brief overview. It is not intended as an all-inclusive explanation of plan benefits. Please read and review all written documentation in order to make an educated and informed decision.

University Medical Center – Benefits Department – Human Resources Delta Point

Sun Life Financial

Group Enrollment form

☐ Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

☐ Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

1 General information

Employer name Clark County, Nevada UMC	Account/policy number 9302	Location 03	Date effective
Street address 1800 W. Charleston Blvd.	City Las Vegas	State NV	Zip code 89015
Type of activity: ■ New Enrollment ☐ Change Reason:		Occupation	

2 Employee information

N

Employee's Full Legal Name (First, MI, Last) ☐ Male ☐ Female			Date of Birth
Street Address	City	State	Zip Code
Marital Status	Social Security Number	Phone number	
Date employed: ☐ Full-Time Date:	☐ Part-Time Date:	☐ Rehire	☐ Return from layoff Date:
Current Active Employment Type _____ # of hours ☐ Full-Time ☐ Part-Time	Employee Status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired		Salary

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies above, outside of New York, and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is. See the Evidence of Insurability section for details.

3 **Benefit elections,** continued

Voluntary Life coverage: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

	Elect Life	Refuse Life	Coverage amount elected
Employee coverage:	☐	☐	Life:
Spouse coverage:	☐	☐	Life:
Child(ren) coverage:	☐	☐	Life:

Family Voluntary AD&D coverage: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

	Elect	Refuse	Coverage amount elected	
Employee election:	☐	☐	$	**Choose One Not Both**
Family election:	☐	☐	$	

Spouse Coverage equals 50% of your (employee) amount if there are no eligible children or 40% of your (employee) amount if there are eligible children. Child(ren) Coverage equals 10% of your (employee) amount if there is spouse coverage, or 15% of your (employee) amount if there is no spouse coverage.

4 Dependent information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full legal name (First, MI, Last)	Gender	Social Security number	Date of birth	Check if elected	
					Dep Life	Dep Vol AD&D
Spouse / Partner					☐	☐
Children					☐	☐
					☐	☐
					☐	☐

Primary Beneficiary Designation

5 Beneficiary Designation information, continued

Voluntary Life Insurance – On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiaries are alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Primary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

***** Must equal 100%

Voluntary AD&D Insurance – On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Primary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

***** Must equal 100%

5 **Beneficiary Designation information,** continued

Secondary Beneficiary Designation

Voluntary Life Insurance – On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

***** Must equal 100%

Voluntary AD&D Insurance– On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

***** Must equal 100%

6 Evidence of insurability and authorization information

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage is subject to evidence of insurability and will not go into effect until Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) approves it.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life Assurance Company of Canada. I have read the Evidence of Insurability notice.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

X _____ _____

Employee Signature Today's Date

To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment form.

Contact us

By mail
Sun Life Financial
One Sun Life Executive Park
Wellesley Hills, MA 02481

www.sunlife.com/us

Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET

Rate Sheet

Employee / Spouse - Coverage and **monthly** cost for Employee Voluntary Life
Rates are effective as of January 01, 2022
The chart below shows possible coverage amounts and corresponding costs per month
Find your age bracket (as of the effective date of coverage) to determine the associated cost for the coverage amount you choose

Face Amoun	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$ 10,000	$ 0.60	$ 0.60	$ 0.80	$ 0.90	$ 1.10	$ 1.60	$ 3.00	$ 5.00	$ 6.60	$ 12.70	$ 20.60
$ 20,000	$ 1.20	$ 1.20	$ 1.60	$ 1.80	$ 2.20	$ 3.20	$ 6.00	$ 10.00	$ 13.20	$ 25.40	$ 41.20
$ 30,000	$ 1.80	$ 1.80	$ 2.40	$ 2.70	$ 3.30	$ 4.80	$ 9.00	$ 15.00	$ 19.80	$ 38.10	$ 61.80
$ 40,000	$ 2.40	$ 2.40	$ 3.20	$ 3.60	$ 4.40	$ 6.40	$ 12.00	$ 20.00	$ 26.40	$ 50.80	$ 82.40
$ 50,000	$ 3.00	$ 3.00	$ 4.00	$ 4.50	$ 5.50	$ 8.00	$ 15.00	$ 25.00	$ 33.00	$ 63.50	$ 103.00
$ 60,000	$ 3.60	$ 3.60	$ 4.80	$ 5.40	$ 6.60	$ 9.60	$ 18.00	$ 30.00	$ 39.60	$ 76.20	$ 123.60
$ 70,000	$ 4.20	$ 4.20	$ 5.60	$ 6.30	$ 7.70	$ 11.20	$ 21.00	$ 35.00	$ 46.20	$ 88.90	$ 144.20
$ 80,000	$ 4.80	$ 4.80	$ 6.40	$ 7.20	$ 8.80	$ 12.80	$ 24.00	$ 40.00	$ 52.80	$ 101.60	$ 164.80
$ 90,000	$ 5.40	$ 5.40	$ 7.20	$ 8.10	$ 9.90	$ 14.40	$ 27.00	$ 45.00	$ 59.40	$ 114.30	$ 185.40
$ 100,000	$ 6.00	$ 6.00	$ 8.00	$ 9.00	$ 11.00	$ 16.00	$ 30.00	$ 50.00	$ 66.00	$ 127.00	$ 206.00
$ 110,000	$ 6.60	$ 6.60	$ 8.80	$ 9.90	$ 12.10	$ 17.60	$ 33.00	$ 55.00	$ 72.60	$ 139.70	$ 226.60
$ 120,000	$ 7.20	$ 7.20	$ 9.60	$ 10.80	$ 13.20	$ 19.20	$ 36.00	$ 60.00	$ 79.20	$ 152.40	$ 247.20
$ 130,000	$ 7.80	$ 7.80	$ 10.40	$ 11.70	$ 14.30	$ 20.80	$ 39.00	$ 65.00	$ 85.80	$ 165.10	$ 267.80
$ 140,000	$ 8.40	$ 8.40	$ 11.20	$ 12.60	$ 15.40	$ 22.40	$ 42.00	$ 70.00	$ 92.40	$ 177.80	$ 288.40
$ 150,000	$ 9.00	$ 9.00	$ 12.00	$ 13.50	$ 16.50	$ 24.00	$ 45.00	$ 75.00	$ 99.00	$ 190.50	$ 309.00
$ 160,000	$ 9.60	$ 9.60	$ 12.80	$ 14.40	$ 17.60	$ 25.60	$ 48.00	$ 80.00	$ 105.60	$ 203.20	$ 329.60
$ 170,000	$ 10.20	$ 10.20	$ 13.60	$ 15.30	$ 18.70	$ 27.20	$ 51.00	$ 85.00	$ 112.20	$ 215.90	$ 350.20
$ 180,000	$ 10.80	$ 10.80	$ 14.40	$ 16.20	$ 19.80	$ 28.80	$ 54.00	$ 90.00	$ 118.80	$ 228.60	$ 370.80
$ 190,000	$ 11.40	$ 11.40	$ 15.20	$ 17.10	$ 20.90	$ 30.40	$ 57.00	$ 95.00	$ 125.40	$ 241.30	$ 391.40
$ 200,000	$ 12.00	$ 12.00	$ 16.00	$ 18.00	$ 22.00	$ 32.00	$ 60.00	$ 100.00	$ 132.00	$ 254.00	$ 412.00
$ 210,000	$ 12.60	$ 12.60	$ 16.80	$ 18.90	$ 23.10	$ 33.60	$ 63.00	$ 105.00	$ 138.60	$ 266.70	$ 432.60
$ 220,000	$ 13.20	$ 13.20	$ 17.60	$ 19.80	$ 24.20	$ 35.20	$ 66.00	$ 110.00	$ 145.20	$ 279.40	$ 453.20
$ 230,000	$ 13.80	$ 13.80	$ 18.40	$ 20.70	$ 25.30	$ 36.80	$ 69.00	$ 115.00	$ 151.80	$ 292.10	$ 473.80
$ 240,000	$ 14.40	$ 14.40	$ 19.20	$ 21.60	$ 26.40	$ 38.40	$ 72.00	$ 120.00	$ 158.40	$ 304.80	$ 494.40
$ 250,000	$ 15.00	$ 15.00	$ 20.00	$ 22.50	$ 27.50	$ 40.00	$ 75.00	$ 125.00	$ 165.00	$ 317.50	$ 515.00
$ 260,000	$ 15.60	$ 15.60	$ 20.80	$ 23.40	$ 28.60	$ 41.60	$ 78.00	$ 130.00	$ 171.60	$ 330.20	$ 535.60
$ 270,000	$ 16.20	$ 16.20	$ 21.60	$ 24.30	$ 29.70	$ 43.20	$ 81.00	$ 135.00	$ 178.20	$ 342.90	$ 556.20
$ 280,000	$ 16.80	$ 16.80	$ 22.40	$ 25.20	$ 30.80	$ 44.80	$ 84.00	$ 140.00	$ 184.80	$ 355.60	$ 576.80
$ 290,000	$ 17.40	$ 17.40	$ 23.20	$ 26.10	$ 31.90	$ 46.40	$ 87.00	$ 145.00	$ 191.40	$ 368.30	$ 597.40
$ 300,000	$ 18.00	$ 18.00	$ 24.00	$ 27.00	$ 33.00	$ 48.00	$ 90.00	$ 150.00	$ 198.00	$ 381.00	$ 618.00
$ 310,000	$ 18.60	$ 18.60	$ 24.80	$ 27.90	$ 34.10	$ 49.60	$ 93.00	$ 155.00	$ 204.60	$ 393.70	$ 638.60
$ 320,000	$ 19.20	$ 19.20	$ 25.60	$ 28.80	$ 35.20	$ 51.20	$ 96.00	$ 160.00	$ 211.20	$ 406.40	$ 659.20
$ 330,000	$ 19.80	$ 19.80	$ 26.40	$ 29.70	$ 36.30	$ 52.80	$ 99.00	$ 165.00	$ 217.80	$ 419.10	$ 679.80
$ 340,000	$ 20.40	$ 20.40	$ 27.20	$ 30.60	$ 37.40	$ 54.40	$ 102.00	$ 170.00	$ 224.40	$ 431.80	$ 700.40
$ 350,000	$ 21.00	$ 21.00	$ 28.00	$ 31.50	$ 38.50	$ 56.00	$ 105.00	$ 175.00	$ 231.00	$ 444.50	$ 721.00
$ 360,000	$ 21.60	$ 21.60	$ 28.80	$ 32.40	$ 39.60	$ 57.60	$ 108.00	$ 180.00	$ 237.60	$ 457.20	$ 741.60
$ 370,000	$ 22.20	$ 22.20	$ 29.60	$ 33.30	$ 40.70	$ 59.20	$ 111.00	$ 185.00	$ 244.20	$ 469.90	$ 762.20
$ 380,000	$ 22.80	$ 22.80	$ 30.40	$ 34.20	$ 41.80	$ 60.80	$ 114.00	$ 190.00	$ 250.80	$ 482.60	$ 782.80
$ 390,000	$ 23.40	$ 23.40	$ 31.20	$ 35.10	$ 42.90	$ 62.40	$ 117.00	$ 195.00	$ 257.40	$ 495.30	$ 803.40
$ 400,000	$ 24.00	$ 24.00	$ 32.00	$ 36.00	$ 44.00	$ 64.00	$ 120.00	$ 200.00	$ 264.00	$ 508.00	$ 824.00
$ 410,000	$ 24.60	$ 24.60	$ 32.80	$ 36.90	$ 45.10	$ 65.60	$ 123.00	$ 205.00	$ 270.60	$ 520.70	$ 844.60
$ 420,000	$ 25.20	$ 25.20	$ 33.60	$ 37.80	$ 46.20	$ 67.20	$ 126.00	$ 210.00	$ 277.20	$ 533.40	$ 865.20
$ 430,000	$ 25.80	$ 25.80	$ 34.40	$ 38.70	$ 47.30	$ 68.80	$ 129.00	$ 215.00	$ 283.80	$ 546.10	$ 885.80
$ 440,000	$ 26.40	$ 26.40	$ 35.20	$ 39.60	$ 48.40	$ 70.40	$ 132.00	$ 220.00	$ 290.40	$ 558.80	$ 906.40
$ 450,000	$ 27.00	$ 27.00	$ 36.00	$ 40.50	$ 49.50	$ 72.00	$ 135.00	$ 225.00	$ 297.00	$ 571.50	$ 927.00
$ 460,000	$ 27.60	$ 27.60	$ 36.80	$ 41.40	$ 50.60	$ 73.60	$ 138.00	$ 230.00	$ 303.60	$ 584.20	$ 947.60
$ 470,000	$ 28.20	$ 28.20	$ 37.60	$ 42.30	$ 51.70	$ 75.20	$ 141.00	$ 235.00	$ 310.20	$ 596.90	$ 968.20
$ 480,000	$ 28.80	$ 28.80	$ 38.40	$ 43.20	$ 52.80	$ 76.80	$ 144.00	$ 240.00	$ 316.80	$ 609.60	$ 988.80
$ 490,000	$ 29.40	$ 29.40	$ 39.20	$ 44.10	$ 53.90	$ 78.40	$ 147.00	$ 245.00	$ 323.40	$ 622.30	$ 1,009.40
$ 500,000	$ 30.00	$ 30.00	$ 40.00	$ 45.00	$ 55.00	$ 80.00	$ 150.00	$ 250.00	$ 330.00	$ 635.00	$ 1,030.00

Child - Coverage and **monthly** cost for Child Voluntary Life.

Rates are effective as of January 01, 2021.

The chart below shows possible coverage amounts and corresponding costs per month.

Coverage Amounts	Cost per Month
$2,500	0.35
$5,000	0.70
$7,500	1.05
$10,000	1.40
$12,500	1.75
$15,000	2.10
$17,500	2.45
$20,000	2.80

Rate Sheet

Employee – Coverage and **monthly** cost for Family Voluntary AD&D.

Rates are effective January 01, 2018.
The chart below shows possible coverage and corresponding costs per month.

Coverage Amounts	Cost Per Month
$ 10,000	0.30
$ 20,000	0.60
$ 30,000	0.90
$ 40,000	1.20
$ 50,000	1.50
$ 60,000	1.80
$ 70,000	2.10
$ 80,000	2.40
$ 90,000	2.70
$100,000	3.00
$110,000	3.30
$120,000	3.60
$130,000	3.90
$140,000	4.20
$150,000	4.50
$160,000	4.80
$170,000	5.10
$180,000	5.40
$190,000	5.70
$200,000	6.00
$210,000	6.30
$220,000	6.60
$230,000	6.90
$240,000	7.20
$250,000	7.50
$260,000	7.80
$270,000	8.10
$280,000	8.40
$290,000	8.70
$300,000	9.00

Rate Sheet

Family – Coverage and **monthly** cost for Family Voluntary Accidental Death & Dismemberment Insurance. Family coverage includes employee, spouse and child(ren).

Spouse – Coverage equals 50% of your (employee) amount if there are no eligible children or 40% of your (employee) amount if there are eligible children.

Child(ren) – Coverage equals 10% of your (employee) amount if there is a spouse coverage, or 15% of your (employee) amount if there is no spouse coverage.

Rates are effective January 01, 2018.

Coverage Amounts	Cost Per Month
$ 10,000	0.40
$ 20,000	0.80
$ 30,000	1.20
$ 40,000	1.60
$ 50,000	2.00
$ 60,000	2.40
$ 70,000	2.80
$ 80,000	3.20
$ 90,000	3.60
$100,000	4.00
$110,000	4.40
$120,000	4.80
$130,000	5.20
$140,000	5.60
$150,000	6.00
$160,000	6.40
$170,000	6.80
$180,000	7.20
$190,000	7.60
$200,000	8.00
$210,000	8.40
$220,000	8.80
$230,000	9.20
$240,000	9.60
$250,000	10.00
$260,000	10.40
$270,000	10.80
$280,000	11.20
$290,000	11.60
$300,000	12.00

EMPLOYEE ENROLLMENT FORM

Flexible Spending Account (FSA)

Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected.
Return the completed and signed form to your employer for processing

For Employer to complete where applicable:

Employer Name: **UMC**

Employer TASC ID # 4821-5577-2232

PRNR _____

Employer Department _____

Participant Plan Effective Date

First Payroll Date _____

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		MI:		Last Name:	
TASC ID # (if known):		Email Address[1]:			
Primary Phone #:		Mobile Phone #[1]:			
Primary Address	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	
Date of Birth:		Hire Date:		Payroll Frequency:	**Bi-Weekly**

All fields are required for account setup. Information is confidential and is not used for marketing purposes.

[1]*Please provide this information if available (not required).*

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

	I select the following benefits and amount(s) to be deducted pretax:		Employee Annual Election Amount	Employee Minimum Annual Election	Employee Maximum Annual Election
☐	**Healthcare FSA (Annual Election / 24 Pay Periods)**	$		$ 0	$3,050
☐	**Dependent Care FSA (Daycare Expenses) (Annual Election / 24 Pay Periods)**	$		$0	$5,000 $2,500 if married filing single

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** **(No fee)**	
2	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	

3	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

EMPLOYEE ENROLLMENT FORM
Flexible Spending Account (FSA)

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses 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 amounts remaining in my flexible spending 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 FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature: _____ Date: _____

ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable benefit account type:

1. **Healthcare FSA Election:** This amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental expenses, orthodontic expenses, eye care, and other eligible healthcare expenses. Per IRS regulations, a participant may elect a maximum based on the current IRS limits. Your employer may have a plan year maximum less than the IRS allowed amount. Review your Summary Plan Description (SPD) or check with your employer for your plan's maximum annual amount. Your annual election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement on the first day of the plan year as eligible expenses are incurred.
2. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the plan year. Your annual contribution must be within the maximum allowable amount under IRS regulations for a family or for married individuals filing single. Plan funds are available as they are contributed.

For assistance: call toll-free 800-422-4661

Have your enrollment form, employer name, and the Client ID# ready.

Find all IRS limits on our resource web page: https://www.tasconline.com/benefits-limits/

TASC | 2302 International Lane | Madison, WI 53704-3140 | 1.800-422-4661 | www.tasconline.com | FX-2008-090519

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose.

©TASC

WELCOME TO CLARK COUNTY

YOU MUST ENROLL IN YOUR VOLUNTARY BENEFITS

You must sign up for your voluntary benefits within 15 days of your hire date.

Trustmark – Universal Life Insurance with Long-Term Care

Guardian – Short Term Disability • Accident
Critical Illness • Cancer • Hospital Indemnity

To learn more about the benefits available to your entity or location, and to sign up for your appointment with a Benefit Counselor go to the website below or click the QR code.

www.myclarkcountybenefits.com

Guardian

Trustmark