**Embassy of the Kingdom of the Netherlands**

**Benefits Enrollment Form**

**IMPORTANT: Plan details and premium amounts can be found in the 2024-2025 Benefits Guide. Please reference the Guide while completing this enrollment form.**

**Select Reason:**  New Hire  Change of Coverage Add/Remove Dependent  Cancel Coverage Became Medicare Eligible Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EMPLOYEE NAME | |  | | | Employee  ID # |  | | | Hire Date |  | | |
|  | |  | | | |
| Address | |  | | | | | | | |  | | |
|  | |  | | | |
| Social Security Number | |  | | Cell Phone |  | | | Email |  | | | |
|  | |  | |  |  | | |  | | | | |
| Marital Status | | Single Married | | Date of Birth  Month/Day/Year | / / | | |  | | | | |
|  | |  | |  |  | | |  | | | | |
| Employment Status | Employee  Retiree  Disabled Retiree | **Citizenship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **If retired:**  Medicare Eligible? | | | Yes  No | | |
| **UHC Medical Plan:**  High  Choice  Base  Medicare Supplement  Waive Coverage  **Coverage Requested:**  Self Only  Self + 1  Self + Family | | **UHC Dental Plan**  **Coverage Requested:**  Self Only  Self + 1  Self + Family  Waive Coverage | | |  | **UHC Vision Plan**  **Coverage Requested:**  Self Only  Self + 1  Self + Family  Waive Coverage | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPENDENTS** | **Name** | **Relationship** | **Social Security #** | **Gender** | **Date of Birth**  **(Month/Date/Year)** | **Coverage(s) Requested** | **Medicare Status** | **Disability Status** |
|  |  |  |  |  |  |  |  |
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Dependent children are eligible to age 26 for medical and vision; to age 19 (24 if student) for dental. If dependents are totally disabled prior to age 26, they may remain on the plan; proof of disability is required.

**Qualifying Event Enrollment Selections** (Complete this section if you are making changes due to a qualifying life event or status change. Supporting documentation must be submitted with your enrollment form):

**Date of Change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Marriage

Birth/Adoption

Death

Divorce

Newly Eligible for Coverage

Loss of Other Coverage

Other, specifically \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approval:**

I hereby apply, on behalf of myself and each dependent listed above, for the coverage elected. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and my employer. I understand that by completing and signing this enrollment form, I am making a binding election with regard to my benefits and that I am authorizing the Embassy to make the deductions necessary to pay my share of the cost of coverage. I further understand that I cannot cancel of change this election unless I experience a Change in Status or am entitled to a Special Enrollment Right and notify HR within 30 days of such an event. I also authorize subsequent payroll deductions in future plan years unless I notify the Embassy of a change in my election.

Retiree Approval:

I understand that as a participant in the retiree plan:

* It is my responsibility to determine whether I am Medicare eligible. This status may change after retirement (e.g., upon turning age 65) and it is my responsibility to know if and when my status changes.
* If I am Medicare eligible, I am required to enroll in Medicare. The Medicare Supplement plan is available to Medicare-eligible retirees at a reduced rate to reflect the offset with Medicare Parts A and B.
* If I drop coverage, I may not re-enroll at a later date.

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

**Questions? Contact Human Resources at** [**\_\_\_\_\_\_\_\_**](mailto:hrstaff@hbi.org)