**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE NAME |  |  Employee ID # |  | Hire Date |  |
|  |  |
| Address |  |  |
|  |   |
| Social Security Number |  | Cell Phone |  | Email |  |
|   |  |  |  |  |
| Marital Status | [ ] Single [ ] Married  | Date of BirthMonth/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  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPENDENTS** | **Name** | **Relationship**  | **Social Security #** | **Gender** | **Date of Birth****(Month/Date/Year)** | **Coverage(s) Requested** | **Medicare Status** | **Disability Status** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

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** **\_\_\_\_\_\_\_\_**