Feb 2024–Jan 2025 **HEALTH** Application

THIS FORM MUST BE COMPLETED BY EVERY EMPLOYEE

EMP ID #	*LAST NAME* *FIRST NAME* *Middle Initial*	*Social Security NUMBER* / /
☐ *Male* ☐ *Female*	*ADDRESS*	*CITY & STATE* / *ZIP CODE*
Work/CELL Phone	*DATE OF BIRTH (Month-Day-Year)* / /	*EMAIL Address*

Please check the YES or NO box below indicating your decision regarding HEALTH INSURANCE COVERAGE.

☐ **YES, I want HEALTH insurance (provided by Waco)**

If I elect dependent coverage, below, I also want my premium deductions made on a pre-tax basis.

☐ **NO, I do NOT want to participate in my employer's HEALTH insurance plan.**

By WAIVING participation, I realize I will not become eligible to participate until next plan anniversary date (Feb 2025) or occurrence of a life event. This waiver will continue in effect until I notify the company in writing. *REQUIRED*: Please tell us WHY, you are refusing (FREE for employee) coverage: Spousal Coverage ____ Individual Policy ____ Other (specify reason) _____

I authorize my employer to make the following salary deductions:

MONTHLY HEALTH INSURANCE PREMIUMS

CIRCLE YOUR CHOICE below:

	ANTHEM© HEALTHKEEPERS POS 30/2000	ANTHEM© KEYCARE PPO 30/2000
EMPLOYEE ONLY	$ 00.00 (paid by Waco)	$ 00.00 (paid by Waco)
Employee & CHILD/CHILDREN	$ 519.20	$ 571.79
Employee & SPOUSE	$ 769.20	$ 847.13
Employee & FAMILY	$ 1,512.71	$ 1,666.00

I cannot change this election during the plan year unless I have a "Life Event", such as termination, change in Employment status, marriage, divorce, death of family member, birth or adoption of a child, or change in benefits by my employer or my spouse's/child's employer. This election replaces any previous election. If you elect to also pay for dependent coverage and have deductions made from your paycheck, you may elect to have those deductions made "pre-tax", which will reduce your federal, state and social security taxes. The only drawback to this plan is that your earnings reported to social security will be less, and when you retire, your social security benefits may be affected by your earnings record. Everyone chooses this Salary Reduction Plan. (Place a check here _____ if you do NOT want to participate in the Salary Reduction Plan for dependent premiums deducted from your paycheck.)

DEPENDENT INFORMATION (complete only if requesting HEALTH insurance coverage for dependents)

RELATIONSHIP to Employee:	NAME: First, Middle & Last NAME (include last name only if different)	GENDER:	DATE of BIRTH: Month/Day/Year	Social Security NUMBER	Full Time Student?
SPOUSE		M ☐ F ☐	/ /	/ /	Yes ☐ No ☐
Dependent CHILD		M ☐ F ☐	/ /	/ /	Yes ☐ ☐
Dependent CHILD		M ☐ F ☐	/ /	/ /	Yes ☐ ☐
Dependent CHILD		M ☐ F ☐	/ /	/ /	Yes ☐ ☐

Signature: _____ Date: _____

RETURN COMPLETED FORM TO: Waco, Inc. Attention: Bonnie Ballsrud, P.O. Box 829 Sandston, VA 23150

Any questions? Contact: bballsrud@wacoinc.net phone: (804) 226-3206/ fax (804) 859-2687