ARHA Enrollment / Change Form

Office Use Only	
Company Info.	Business Name: _____ Contact Name:_____ Phone:_____ Email:_____
Enrollment	☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ Qualifying Event
Change	☐ Personal Information ☐ Beneficiary ☐ Add Dependent ☐ Other: _____
Termination	Termination Date: _____ Coverage End Date: _____ Reason: _____
Qualifying Event	☐ Marriage/Divorce ☐ Birth/Adoption ☐ Court Order ☐ Loss of Coverage ☐ FT to PT (Last Day of FT Coverage _____)

Employee Information			
Social Security Number	Last Name	First Name	MI
Home Street Address	Apt	City, State, Zip	
Date of Birth	Date of Hire	Gender (required) ☐ Male ☐ Female	Employment Status ☐ Full-Time ☐ Part-Time

Dependent Information						
Last Name	First Name	SSN	Date of Birth	Gender (M / F)	Relationship	Coverage
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision
					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

					☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ Vision

Elections					
Premier Medical	Value Medical	Bronze Medical	Enhanced Dental	Basic Dental	Vision
☐ Employee Only $630.73	☐ Employee Only $588.13	☐ Employee Only $555.66	☐ Employee Only $30.90	☐ Employee Only $25.74	☐ Employee Only $13.34
☐ Employee + Spouse $1,237.73	☐ Employee + Spouse $1,148.27	☐ Employee + Spouse $1,083.32	☐ Employee + Spouse $59.54	☐ Employee + Spouse $49.65	☐ Employee + Spouse $18.94
☐ Employee + Children $1,144.90	☐ Employee + Children $1,066.49	☐ Employee + Children $1,006.43	☐ Employee + Children $73.62	☐ Employee + Children $55.76	☐ Employee + Children $19.25
☐ Family $1,758.77	☐ Family $1,626.63	☐ Family $1,534.09	☐ Family $110.42	☐ Family $85.10	☐ Family $28.59
☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____	☐ Decline Reason: _____

River Health Primary Care Option				
☐ Employee Only $54	☐ Employee + Spouse $74	☐ Employee + Children $134	☐ Family $164	☐ Decline Reason: _____

I have read this form and the other materials given to me about my benefits and certify the information I have supplied is correct. I understand that misstatements, misrepresentations, or omissions may result in my coverage being canceled. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary action up to and including termination.

I also understand that the benefit coverages I elect on this form will be in effect for the entire plan year unless I experience a qualified status change event and request a change to my benefits within 30 days of such event. By signing and submitting this enrollment form, I authorize my employer and/or affiliates to deduct from my earnings or wages voluntary contributions to company-sponsored employee benefit programs. I also understand that I am liable for these deductions pursuant to such authorization and acknowledge that it is my responsibility to verify that these payroll deductions are correct. I will notify human resources immediately in writing upon discovering any discrepancy.

Employee Signature: _____ Date: _____