CAJUN INDUSTRIES, LLC

GROUP INSURANCE ENROLLMENT FORM (Rev 10/2014)
For Health, Dental, Vision, & Short-Term Disability

Last Name	First Name	Middle Initial	Social Security Number

Mailing Address	City	State	Zip Code	Home or Cell Phone Number

Marital Status	Sex	Date of Birth	Date Hired Full Time	Email Address
[ ] Married [ ] Seperated [ ] Single [ ] Divorced	[ ] Male [ ] Female	Month Day Year	Month Day Year	

Occupation	EE Life	Status		
	[x] Yes [ ] No	[ ] New Employee [ ] Retiree	[ ] Rehire Date: [ ] Special Enrollee	[ ] Late Enrollee [ ] Disabled

CHOOSE ONE HEALTH PLAN OPTION BELOW

PLAN I (Traditional Plan)	Premium	PLAN II (High Deductible Plan)	Premium
Employee Only	[ ] $42.00 / Week	Employee Only	[ ] $14.00 / Week
Employee + One Dependent	[ ] $91.00 / Week	Employee + One Dependent	[ ] $49.00 / Week
Employee + Family	[ ] $126.00 / Week	Employee + Family	[ ] $70.00 / Week

VOLUNTARY / OPTIONAL SHORT-TERM DISABILITY - EMPLOYEE ONLY (Choose One)

[ ] Do Not Want Short-Term Disability [ ] Yes I Want Short-Term Diability. Weekly cost is the amount of weekly benefit divided by 10 * $0.14

VOLUNTARY / OPTIONAL VISION (Choose One)	VOLUNTARY / OPTIONAL DENTAL (Choose One)
[ ] Do Not Want Vision [ ] Employee Only $1.65 / Week [ ] Employee + One $3.17 / Week [ ] Employee + Family $5.39 / Week	[ ] Do Not Want Dental [ ] Employee Only $6.35 / Wk [ ] Employee + Family $15.24 / Wk

COMPLETE IF DEPENDENT COVERAGE IS REQUESTED
*****Complete Spousal Coverage Affidavit on reverse side if electing spousal coverage*****

Relationship	Name	Enroll Dependent In	Date of Birth	SSN	Sex (circle one)
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female

Do you or your dependents currently have other health insurance? [ ] Yes or [ ] No. If yes, give name of policyholder, policy #, name of insured, insurance company, effective date, and if applicable, termination date.

BENEFICIARY

I hereby direct payment of any death benefit under the Plan to the beneficiary listed below. Unless otherwise provided, if more than one beneficiary is designated in any one class, each beneficiary in the same class shall share equally.

First Name **Middle Initial** **Last Name** **Relationship**

AGREEMENT

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and hereby authorize my employer to deduct from my earnings the required contributions. All contributions will be deducted on a pre-tax basis, except for short-term disability premiums.

Signature of Employee **Date**

WAIVER OF COVERAGE

I have decided not to apply for coverage offered as checked below. I understand that the Affordable Care Act requires individuals to have health insurance through their employer or some other source such as government sponsored healthcare exchange or be subject to a penalty. I understand that Cajun's health plan meets the minimum value standard and is intended to be affordable.

MEDICAL [ ] Self [ ] Dependents DENTAL [ ] Self [ ] Dependents
VISION [ ] Self [ ] Dependents LIFE [ ] Self [ ] Dependents

I decline such coverage because:
[ ] My spouse is employed by _____ and is insured for similar health benefits.
[ ] My children have health coverage under (plan or policy name) _____.
[ ] Other Reasons (explain) _____.
_____.

Employee Signature **Print Name** **Date**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement.

Mail Enrollment Form to: P.O. Box 104 Baton Rouge, LA 70821 ATTN: Benefits Department

Spousal Coverage Affidavit

All employees enrolling a spouse in Cajun's health insurance plan must verify their spouses' eligibility under the plan. ***A spouse is not an eligible dependent if the spouse is currently employed and his or her employer offers health insurance.***

If your spouse is currently on Cajun's Health Insurance Plan and is no longer eligible due to eligibility of coverage under his or her employer's health insurance plan, your spouse should notify his or her Human Resources department to inform them that they will be losing their coverage under the Cajun Health Insurance Plan. This qualifies as a "Life Event" and gives them the opportunity to enroll in their employer's plan regardless of the open enrollment period as long as they enroll within 30 days of losing their coverage. Cajun will furnish you with a notice for your spouse's employer upon receipt of this affidavit.

This form must be returned to the Benefits Department with your enrollment to ensure that your spouse is eligible to be covered by the health insurance plan.

VERIFICATION OF SPOUSE ELIGIBILITY

In order to confirm that your spouse is eligible to be covered as a dependent on the Cajun medical plan, please complete the following questions.

Is your spouse employed either full-time or part-time?	F-T ☐	P-T ☐	No ☐
If yes, does your spouse's employer offer medical benefits to their employees? If no, you must notify the Benefits Department if your spouse becomes eligible for insurance coverage due to his or her employment status change.	Yes ☐	No ☐	N / A ☐

I hereby certify that I understand that if my spouse has medical coverage available to them through their own employer, they are not eligible to be covered as a dependent on the Cajun Health Insurance Plan.

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. I understand that any misrepresentation or falsification of information I have provided above will permit the Cajun Health Insurance Plan to terminate the spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. I further understand that I must report any changes in my spouse's employment status to the Benefit's Department.

In addition, willful provision of false information may result in disciplinary action up to and including termination of employment.

_____	_____	_____
Print your name here	Social Security or Employee #	Contact Telephone Number

_____	_____
Employee signature	Date signed