CCA Midwest, Inc.
Return this completed form to Kris Mayborne

Benefit Election & Waiver Form

Please complete the following enrollment form for your 2016-2017 benefits. Please select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered by CCA Midwest, Inc. and are therefore waiving all coverage, please check the box for waiving all coverage, complete the top section of the form and sign/date at the bottom of the back page.

☐ **New Hire** ☐ **Change of Status*** **Reason:**_____ ☐ **Waiving All Coverage**

**Change of Status is only applicable if you have experienced a qualifying life event. Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*

Company Name	CCA Midwest, Inc.	Coverage Effective	/ /
Employee Name *(Please print)*		Date of Hire	/ /
Address		City, State, Zip Code	
Date of Birth	/ /	Telephone Number	- -
Gender		Marital Status	
Social Security #	- -		

Medical Coverage - ☐ Please check here if you are making an election change on your medical insurance for the 2016-2017 plan year — Humana

Election	HSA Plan
Employee Only	☐
Employee + Spouse*	☐
Employee + Child(ren)*	☐
Family*	☐

*Note: If any election other than Employee Only is chosen, please complete the Dependent Information on the back page.

☐ **I am choosing to waive medical coverage for myself and my dependents**

Dental Coverage - ☐ Please check here if you are making an election change on your dental insurance for the 2016-2017 plan year — Humana

Election	Dental PPO
Employee Only	☐
Employee + Spouse*	☐
Employee + Child(ren)*	☐
Family*	☐

*Note: If any election other than Employee Only is chosen, please complete the Dependent Information on the back page.

☐ **I am choosing to waive dental coverage for myself and my dependents**

Vision Coverage - ☐ Please check here if you are making an election change on your vision insurance for the 2016-2017 plan year — Humana

Election	Vision
Employee Only	☐
Employee + Spouse*	☐
Employee + Child(ren)*	☐
Family*	☐

*Note: If any election other than Employee Only is chosen, please complete the Dependent Information on the back page.

☐ **I am choosing to waive vision coverage for myself and my dependents**

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship to Employee
	- -	/ /		
	- -	/ /		
	- -	/ /		
	- -	/ /		
	- -	/ /		

PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

Dependent Information continued if needed

Name	Social Security #	Birth Date	Gender	Relationship to Employee
	- -	/ /		
	- -	/ /		
	- -	/ /		
	- -	/ /		
	- -	/ /		

Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. You will not have to fill out carrier enrollment applications in addition to completing this form. Your next opportunity to make changes will be during the 2017 open enrollment period for a 12/1/17 effective date, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact your local Human Resources representative within 30 days of the life status change.

My signature below authorizes CCA Midwest, Inc. to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: / /