2022 DENTAL Benefit Election Form

Employee ID Number:_____

BENEFITS ENROLLMENT/CHANGE REASON

NEW QUALIFYING EVENT (Check one below)

☒ OPEN ENROLLMENT ☐ NEW HIRE (Date ____/____/_____)

MID-YEAR QUALIFYING EVENT (Check one below): Date ____/____/_____

☐ Marriage ☐ Legal Separation ☐ Divorce

☐ Birth/Adoption/Change in Custody ☐ Loss of Other Coverage ☐ Spouse Losing Coverage

☐ Child No Longer Eligible ☐ Court Ordered Benefits ☐ Death of Enrolled Family Member

☐ Other_____

You must provide documentation to support the qualifying event change (e.g., marriage license, birth certificate, divorce decree).

All enrolled family members must be deemed eligible dependents under the provisions of the plan. Sibanye-Stillwater reserves the right to request proof of eligible dependent status at any time. Falsifying company records or knowingly enrolling ineligible dependents may result in disciplinary action up to and including termination of employment.

SECTION A: YOUR PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI:_____

Social Security #_____-_____-_____ Date of Birth: _____ Marital Status: ☐ Single ☐ Married

Home Phone # ( )_____ -_____ Email(required): _____

Address:_____ City_____ State _____ Zip _____

☐ Salary ☐ Bargaining Unit

HR Use Only:

Date of Hire: _____ Location: _____ Division #: _____

SECTION B: EMPLOYEE / DEPENDENT INFORMATION – Attach another sheet for additional dependents

	Check One	Name (Last, First, MI)	Date of Birth (mm/dd/yy)	Social Security #	Gender
Self	__ Add __ Drop		__/__/__	___-___-___	__ Male __ Female
Spouse – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	__ Add __ Drop		__/__/__	___-___-___	__ Male __ Female
Child # 1 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	__ Add __ Drop		__/__/__	___-___-___	__ Male __ Female
Child # 2 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	__ Add __ Drop		__/__/__	___-___-___	__ Male __ Female
Child # 3 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	__ Add __ Drop		__/__/__	___-___-___	__ Male __ Female
Child # 4 – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	__ Add __ Drop		__/__/__	___-___-___	__ Male __ Female

If you need to enroll additional dependents please use an additional enrollment form & staple together.

SECTION C: EMPLOYEE AND DEPENDENT COVERAGE – Check your election:

Dental – You and your dependents must be on the same plan

Select Your Tier

Dental PPO - Delta Dental Network

	Employee Only
	Employee + Spouse
	Employee + Child(ren)
	Employee + Family

SECTION D: ACCEPTANCE OF COVERAGE

PAYROLL AUTHORIZATION

I authorize my employer to deduct from my salary or wages the necessary premium for the coverage elected on this form. My signature verified the accuracy of the information contained on this form. I authorize my employer to take my Healthcare Plan deductions (Dental) on a pre-tax basis. I authorize my employer to deduct such contributions from earnings via payroll deduction until further notice. I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date insurance would otherwise become effective. I have read and understand the information in the Enrollment Kit, including all statements regarding exclusions.

MISREPRESENTATION

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services, I and any enrolled dependents are obligated to understand and abide by the terms, conditions, and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

EMPLOYEE SIGNATURE

I elect coverage as indicated above and consent to all terms and conditions stated above. Furthermore, I declare that the information represented above is true and correct. I have read the Summary Plan Description and understand the post-tax deduction option. My participation in the Plan is subject to all the plan terms and conditions as set forth in the plan documents, Benefit Summaries, and Summary Plan Description.

I understand that I cannot change my elections until the next open enrollment period, but I may change coverage for myself or my dependents if there is a "family status" change. All "family status" changes must be made within 31 days of the qualifying event. See your HR Department for more information.

Employee Signature:	Date:

SECTION E: DECLINATION OF COVERAGE – Complete this portion only if you DO NOT want coverage

DECLINING COVERAGE (declining coverage for yourself and all eligible dependents)

Dental

REASON FOR DECLINING COVERAGE:

__ I am covered by another group health plan (attach proof of coverage) __ Other _____

I understand that insurance coverage has been offered to me and my dependents by My Employer. I decline to participate in the plans at this time. I understand that if I decide to enroll at a later date, I will have to wait until the next Open Enrollment period unless I experience an allowable qualified status change as defined by the Internal Revenue Code (IRC).

Employee Signature:	Date: