

# 2023 MEDICAL Benefit Election/Change Form



Salary       Bargaining      Unit Employee ID Number \_\_\_\_\_

## BENEFITS ENROLLMENT/CHANGE REASON

### NEW QUALIFYING EVENT (Check one below)

- New Hire Date (date: \_\_\_\_\_)       Open Enrollment
- Mid-Year Qualifying Event (Check one below)      Date of event ( \_\_\_\_\_ )
- 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) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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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 _ / _ / _	Social Security # _ - _ - _	Gender	
<b>Self</b>	<input type="checkbox"/> ADD <input type="checkbox"/> DROP				<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Spouse</b> – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP				<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Child # 1</b> – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP				<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Child # 2</b> – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP				<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Child # 3</b> – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP				<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Child # 4</b> – please note, you cannot have duplicate coverage under the Sibanye-Stillwater Health plans	<input type="checkbox"/> ADD <input type="checkbox"/> DROP				<input type="checkbox"/> Male	<input type="checkbox"/> Female

\*If you need to enrol additional dependent(s) please use an additional enrollment form & staple together \*

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

MEDICAL – Please select either the PPO or EPO plan. You and your dependents must be on the same plan

PPO (Select Your Tier Below)	EPO (Select Your Tier Below)	Select Your Medical Group	Select your primary Care Physician
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Billings Clinic - or - <input type="checkbox"/> St. Vincent Healthcare	Employee PCP Name: _____ Spouse PCP Name: _____ Child#1 PCP Name: _____ Child#2 PCP Name: _____ Child#3 PCP Name: _____ Child#4 PCP Name: _____
<p style="color: blue; font-size: small;">*If you select the EPO medical plan you MUST list a Primary Care Physician (PCP)</p>			



## 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.

### SUMMARY OF BENEFITS AND COVERAGE

I hereby acknowledge receipt of the **Summary of Benefits and Coverage (SBC)**. I have read the **SBC** and am familiar with its contents. If I have any questions concerning the information, I will contact the carrier or my Human Resource Department to have my questions answered. I understand this **SBC** is not a contract, and the material represents guidelines subject to change.

### 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)

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:

### To Be Completed by SMC HR

Date change becomes effective with the Sibanye-Stillwater Bargaining Unit Health and/or Dental Plans: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yyyy

Date of Hire (as an eligible employee per Plan Document): \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yyyy

Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions?  Yes  No

Signature of Human Resources Representative: \_\_\_\_\_  
mm/dd/yyyy

Comments/Notes

Date Stamp

