2024 MEDICAL Benefit Election/Change Form

Employee ID Number _____

BENEFITS ENROLLMENT/CHANGE REASON

NEW QUALIFYING EVENT (Check one below)

☐ Open Enrollment
☐ New Hire Date: _____
☐ Mid-Year Qualifying Event Date of Event: _____
☐ Marriage ☐ Legal Separation/Divorce ☐ Birth/Adoption/Change in Custody ☐ Child No Longer Eligible
☐ Loss of Coverage ☐ Spouse Losing Coverage ☐ 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:_____ SSN: _____
Date of Birth: _____ Email: _____ Phone #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

HR USE ONLY:

Location: _____ Department: _____ Division #: _____

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

	Check One	Name(Last, First, Mi)	Date of Birth __/__/____	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 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)

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

EPO (Select Your Tier Below)

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

*If you select the EPO medical plan you **MUST** list a Primary Care Physician (PCP)

Select Your Medical Group

☐ Billings Clinic
- or –
☐ St. Vincent Healthcare

Select your primary Care Physician

Employee PCP Name: _____
Spouse PCP Name _____
Child#1 PCP Name _____
Child#2 PCP Name _____
Child#3 PCP Name _____
Child#4 PCP Name _____

INNOVATION COMMITMENT ACCOUNTABILITY RESPECT ENABLING SAFETY

Last Name: _____ First Name: _____ Employee #: _____

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 o pen 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)

☐ 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 Medical Plan: _____ 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