LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

# 2021 BENEFIT ENROLLMENT FORM

*Benefit rates January 1 – December 31, 2021*

**Effective date of Coverage** _____

**REASON** ____ **NEWLY ELIGIBLE - Benefits** *effective on first of the month following 30 days of employment.*

____ **QUALIFIED EVENT – Benefits** *effective on the date of the qualified event*

| | | |
|---|---|---|
| Employee Last Name First Middle | Social Security Number: | Date of Birth (Mo./Day/Yr) ☐ Male ☐ Female |
| Employee's Address Number Street Address Name Apt # | | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced |
| City State Zip Code | | Email Address: |

**DEPENDENT INFORMATION** – ALL data, including social security number must be completed in order to enroll your dependent.

| | Last Name, First, Middle Initial | Social Security # | Birth Date | Gender M/F |
|---|---|---|---|---|
| *Spouse* | | | | |
| *Child* | | | | |
| *Child* | | | | |
| *Child* | | | | |

## CHOOSE ONE: HEALTH INSURANCE

### Anthem HSA BASE

| | Cost Per Paycheck (Bi-Weekly)** |
|---|---|
| Employee Only ☐ | $79.00 |
| Employee + Child ☐ | $171.36 |
| Employee + Children ☐ | $189.08 |
| Employee + Spouse ☐ | $220.06 |
| Family ☐ | $327.25 |

### Anthem HSA PREMIUM

| | Cost Per Paycheck (Bi-Weekly)** |
|---|---|
| Employee Only ☐ | $92.94 |
| Employee + Child ☐ | $201.60 |
| Employee + Children ☐ | $222.45 |
| Employee + Spouse ☐ | $258.90 |
| Family ☐ | $385.00 |

### Anthem Health Keepers Value Advantage 25/500 OA POS

| | Cost Per Paycheck (Bi-Weekly)** |
|---|---|
| Employee Only ☐ | $142.48 |
| Employee + Child ☐ | $293.79 |
| Employee + Children ☐ | $314.63 |
| Employee + Spouse ☐ | $361.24 |
| Family ☐ | $531.67 |

☐ **WAIVE / NO Health Insurance** - I do NOT wish to participate in the LMG Health Insurance Benefits in 2021.

### Anthem Health Keepers 10 POS

| | Cost Per Paycheck (Bi-Weekly)** |
|---|---|
| Employee Only ☐ | $227.41 |
| Employee + Child ☐ | $451.74 |
| Employee + Children ☐ | $472.57 |
| Employee + Spouse ☐ | $539.95 |
| Family ☐ | $783.02 |

## CHOOSE ONE: DENTAL INSURANCE

### ANTHEM Dental Services

| | Cost Per Paycheck (Bi-Weekly) |
|---|---|
| Employee Only ☐ | $11.70 |
| Employee + Child ☐ | $24.41 |
| Employee + Children ☐ | $32.32 |
| Employee + Spouse ☐ | $25.15 |
| Family ☐ | $32.32 |
| WAIVE / NO VISION ☐ | |

## CHOOSE ONE: VISION INSURANCE

### ANTHEM Vision Services

| | Cost Per Paycheck (Bi-Weekly) |
|---|---|
| Employee Only ☐ | $2.47 |
| Employee + Child ☐ | $5.20 |
| Employee + Children ☐ | $5.20 |
| Employee + Spouse ☐ | $4.96 |
| Family ☐ | $8.43 |
| WAIVE / NO VISION ☐ | |

** *The health insurance rates provided are basic rates. Employees who have used tobacco products in the last 6 months will have a 10% health insurance surcharge.*
*All employees enrolling in health insurance MUST complete the Health Insurance Tobacco Affidavit form. Employees who do not provide this form will be charged a 10% surcharge.*
***QUESTIONS ABOUT COVERAGE OPTIONS?*** *Contact Human Resources - Maggie Colucci at mcolucci@lmgdoctors.com*

**IMPORANT – PLEASE READ** *I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan(s). Any misstatement or omissions may result in future claims being denied and/or the policy being rescinded. If applicable, I authorize my employer to deduct any required contributions from my earnings each pay period on a pre-tax basis unless I have provided written instructions to do otherwise. I understand that the rates provided on this form are the base rates and that my contribution may be different based on my wellness program participation and tobacco use status.I understand that my pre-tax benefit elections are binding, and that I may not enroll, drop or make changes to these benefit elections until the next open enrollment period or I experience a qualified life event. I understand that if I experience a qualified life event and wish to make changes to my benefit elections, I must do so within 30 calendar days of that event.*

_____ _____

**Employee Signature** **Date**

*Return this completed form, along with all other supporting documentation to*
*your office manager or designated office liaison - or email lmgpayroll-hr@lmgdoctors.com - or fax to 703-443-8174 within 30 days of the coverage effective date.*