KELLY & ASSOCIATES INSURANCE GROUP, INC.

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EMPLOYEE ELECTION FORM

☐ New Subscriber ☐ Member adding line of coverage ☐ WAIVER (*signature required*) ☐ COBRA or State Continuation ☐ Retiree

Company Name:	Orion Consortium, LLC	**KELLY Company ID:**		**Business Phone:**	410-923-5585

1 EMPLOYEE

Last Name	First Name	MI	Title (Jr., Sr., etc.)

Street Number	Street Name *Note: a PO Box is insufficient for any HSA, FSA, or HRA account*	Apt #

City	State	Zip Code	E-mail

Social Security #	Date of Birth (MM-DD-YY)	Gender M ☐ F ☐	Marital Status Single ☐ Married ☐ Partner* ☐	On your effective date, will you be actively at work on a full-time basis for this employer? ☐ Y ☐ N	Hrs/week
					40

Home Phone	Full-time Hire Date (MM-DD-YY)	***Employer Use Only:*** Requested Effective Date (MM-DD-YY)	KELLY USE ONLY: G

** Domestic partner coverage availability is based on carrier and employer authorization.*

2 DEPENDENTS

Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Gender	F/T Student (Y/N)**	Disabled (Y/N)	Tobacco (Y/N)	Dependent Elections Health	Dependent Elections Dental	Dependent Elections Vision	Primary Care Physician (POS or HMO plans only) Physician Name	Primary Care Physician (POS or HMO plans only) PCP ID#	Existing Patient (Y/N)
	Subscriber						N						
				F	N	N	N	☐	☐	☐			
				F	N	N	N	☐	☐	☐			
				F	N	N	N	☐	☐	☐			
				F	N	N	N	☐	☐	☐			

*** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)*

Participating Dentist Name/Code/Office#: Existing Patient: ☐ Y ☐ N

If Eligible for Medicare: Effective Date (Part A): Effective Date (Part B): Effective Date (Part D):

3 PLANS

HEALTH	**DENTAL**	**VISION**
Group#	Group#:	Group#
Carrier	Carrier	Carrier
Plan	Plan	Plan
☐ Individual	☐ Individual	☐ Individual
☐ Individual & Child(ren)	☐ Individual & Child(ren)	☐ Individual & Child(ren)
☐ Individual & Adult	☐ Individual & Adult	☐ Individual & Adult
☐ Family	☐ Family	☐ Family
☐ Over 65 & Working FT	☐ Waive Coverage	☐ Waive Coverage
☐ Over 65 & Retired		
☐ Waive Coverage		

CDH Funding: ☐ HRA ☐ HSA **Contrib. Amount $** ☐ FSA **Contrib. Amount $** ☐ DCAP **$**

	Plan Name	**Benefit Amount**	**Smoker?**
☐ Life AD&D		$	☐ Y
☐ Vol. Life		$	☐ Y
☐ Vol. AD&D		$	☐ Y
☐ Vol. Sp. Life		$	☐ Y
☐ Vol. Dep. Life		$	☐ Y
☐ STD		$ **/week**	
☐ Vol. STD		$ **/week**	
☐ LTD		$ **/month**	
☐ Vol. LTD		$ **/month**	
☐ Supp. Life/AD&D		$	

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Employee Occupation:	Employee Class:	Employee Salary:

Primary Beneficiary: Relationship:

Secondary Beneficiary: Relationship:

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name:

Who is covered? ☐ Self ☐ Spouse/Partner ☐ All Policy#

Effective Date: Term Date:

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that the dependents listed above are eligible to enroll in the plan(s) selected. **If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.**

THIS IS NOT AN APPLICATION FOR INSURANCE

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EMPLOYEE SIGNATURE: **DATE:**

EMPLOYER SIGNATURE / VERIFICATION: **DATE:**

9.15.13

KELLY & ASSOCIATES INSURANCE GROUP, INC.
WAIVER OF INSURANCE COVERAGE

Medical/Dental/Vision/Medicaid & State Children's Health Insurance Program (SCHIP)
Notice of Special Enrollment Period

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days for Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/ dental/vision coverage.

Non-Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation,
2. Birth or adoption of a child,
3. Death of a spouse or child,
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s),
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes),
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job),
7. Loss or eligibility for Medicaid or SCHIP Coverage.

Notice to the Insured: The insurance carrier sells insurance products pursuant to which eligible employees of the policyholder may obtain coverage. Kelly & Associates Insurance Group, Inc. actively administers the insurance carrier's health insurance program. Premiums are made by the policyholder to KELLY on behalf of eligible employees. These amounts are then forwarded to the insurance carrier that provides the benefits for the eligible employee. KELLY is authorized by the insurance carrier to perform the following functions for group health benefit plans and all other insurance products issued, administered or marketed by the insurer:

- Process enrollment activity
- Collect premiums and remit payments to the carrier
- Answer questions pertaining to enrollment activity, invoice or benefit inquiries

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.