NEW HIRE/OPEN ENROLLMENT FORM

Forms must be submitted to Employer or Kairos within 30 days of the hire date, except as noted in the Plan Document/Summary Plan Description. Failure to submit forms within the required period will impact the participant's benefits and/or enrollment. Kairos is not responsible for untimely form submission, or for lost forms.

Employer Name: Highlands Fire District

SECTION A: ENROLLMENT

☐ New Hire ☐ Open Enrollment ☐ Rehire

SECTION B: EMPLOYEE INFORMATION

Last Name ________________ First Name ________________ M.I. ______

SSN ________________ DOB (M/D/Y) ________________ Gender ☐ M ☐ F

Mailing Address ________________________________

City ________________ State ________________ Zip ________________

Phone ________________ Email ________________

Marital Status ☐Single ☐Married Tier Selection ☐ Active ☐ Retiree ☐ Board Member

SECTION C: DEPENDENT INFORMATION

Last Name, First, M.I.	SSN	Relationship to Employee	Gender	DOB (M/D/Y)

Dependents age 26 and older are not eligible to be enrolled for benefits, unless disabled.
If enrolling a domestic partner and allowed by your Employer, a statement of domestic partnership must be completed and submitted with this form.

SECTION D: MEDICAL

Select plan and who you wish to cover.
Employees and dependents must be enrolled in the same plan option.

☐	☐	☐
$1,600 HDHP Non-embedded Deductible*	**$2,500 HDHP** Non-embedded Deductible*	**$5,000 HDHP** Embedded Deductible*

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

**See your Employer for details on embedded vs. non-embedded deductibles*

☐ If enrolling in the HDHP, I elect to contribute $________________ annually into my Health Savings Account (HSA).
(2024 maximum of $4,150 annually for employee only / maximum of $8,300 for employee + dependents)

SECTION E: DENTAL AND VISION

Delta Dental	☐ Employee	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Waive
VSP Vision	☐ Employee	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Waive

SECTION F: BASIC LIFE INSURANCE BENEFICIARIES

Last Name, First, M.I.	Relationship to Employee	Percentage (must equal 100%)

Basic Life is 100% Employer sponsored; therefore, you cannot opt out of basic life coverage.

KAIROS
HEALTH ARIZONA, INC.

SECTION G: ANCILLARY BENEFITS & EMPLOYEE SIGNATURE

Prepaid Legal
Select plan

☐ Low plan
☐ High plan

☐ Waive

Identity Theft Protection
Select plan and who you wish to cover

☐ Total plan
☐ Premier plan
☐ Ultimate Plan

☐ Employee
☐ Employee + Family

☐ Waive

READ CAREFULLY

- I understand that certain benefits under this Plan are pre-tax. I authorize the deduction of health care premium payments from my before-tax pay that will be applied to the cost of the coverages elected. I understand that the cost of coverage may be changed annually or as announced by my Employer.
- I understand that the premiums for domestic partner health benefits may not be paid on a pre-tax basis unless the domestic partner is eligible for tax free health coverage under federal tax laws (e.g. is a tax qualified dependent).
- I understand that the benefits elected must remain in force for the entire Plan Year and that I may not make a change in my coverage or contribution during that Plan Year, unless there is a qualified change in status as defined under the Plan in accordance with the Internal Revenue Code regulations.

Employee Signature ______________________________ **Date** ______________

SECTION H: FOR HR USE ONLY—DO NOT WRITE BELOW THIS LINE

Date of Hire ______________ **Coverage Effective Date** ______________ **Salary** ______________

If eligible due to full time status, enter date of full-time employment ______________________

Employer Signature ______________________________ **Date** ______________