

# POLESTAR BENEFITS, INC. - EMPLOYEE ENROLLMENT FORM

SUBMIT FORMS TO: 412 Jefferson Parkway, Suite 202 - Lake Oswego, OR 97035 **OR** Fax (888) 539-9565

EMPLOYER INFORMATION					
Employer Name	Location	Group #			
EMPLOYEE INFORMATION					
Last Name		First Name		MI	
Street/Mailing Address		City	State	Zip	
Social Security Number		Date of Birth	Date of Hire	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Email * Required for Benefit Card Participation	ENROLLMENT TYPE		I ELECT TO ENROLL IN		
	<input type="checkbox"/> Open Enrollment / New Hire		<input type="checkbox"/> Health Reimbursement Arrangement (HRA)		
	<input type="checkbox"/> Add / Change:		<input type="checkbox"/> Flexible Spending Arrangement (FSA)		
		EFFECTIVE DATE:		<input type="checkbox"/> Dependent Care Spending Arrangement (DCAP)	
DEPENDENT INFORMATION					
Spouse Name	Date of Birth	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE	Child Name	Date of Birth	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE
Child Name	Date of Birth	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE	Child Name	Date of Birth	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE
Child Name	Date of Birth	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE	Child Name	Date of Birth	<input type="checkbox"/> ENROLL <input type="checkbox"/> WAIVE
MEDICARE INFORMATION					
Are you, your spouse or dependent(s) covered by Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, refer to your Medicare Card to complete this section)					
Cardholder Name	Medicare ID #	Effective Dates	Medicare Entitlement Reason <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ALS <input type="checkbox"/> Kidney Failure		
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SECTION 125 – FLEXIBLE (FSA) & DEPENDENT CARE (DCAP) SPENDING ACCOUNT INFORMATION					
Flexible Spending Account ANNUAL ELECTION MAXIMUM IS \$		Pay Period Election	# of Pay Periods X	ANNUAL ELECTION \$	
Dependent Care Spending Account ANNUAL ELECTION MAXIMUM IS \$		Pay Period Election	# of Pay Periods X	ANNUAL ELECTION \$	
ACKNOWLEDGEMENT AND AUTHORIZATION					
<b>SIGN BELOW TO ENROLL</b>	<p>I hereby request coverage as outlined above under the Polestar Benefits, Inc., Madison National Life Insurance Company, Inc. of Wisconsin, and/or Standard Security Life Insurance Company of New York group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.***125/FSA and HRA Acknowledgement*** The dependents for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for support. I am aware the premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded. Reimbursement account claims must be accompanied by proper documentation (i.e. a reimbursement request and related receipt(s) or Explanation of Benefits) of the out-of-pocket expense and be incurred within the plan year. This agreement cannot be revoked or changed, unless I experience a qualified change in status.</p> <p><b>WARNING:</b> Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud, which is a crime.</p>				
Employee Signature				Date	
DECLINATION OF PARTICIPATION					
My Employer's Plan(s) has been explained to me; I have been given the opportunity to participate and have elected NOT to do so in the selected options to follow: <input type="checkbox"/> HRA <input type="checkbox"/> Flexible Spending Account <input type="checkbox"/> Dependent Care Spending Account					
Employee Signature				Date	