HUMANA EMPLOYEE ENROLLMENT FORM

Employee Information

Last Name | First Name | Gender: O Female O Male

Social Security Number | Date of Birth

Date of Hire | Effective Date of Coverage

Employee Address Information

Mailing Address | Apt/Suite/PO Box #

City | State | Zip Code

Home Phone

Medical Plan Selection (MUST CHECK ONE)

NPOS HDHP		NPOS COPAY 14		Waive Coverage	

Coverage Level

O Employee Only
O Employee/ Spouse
O Employee/Child(ren)
O Employee/ Family

Dependent Information

Last Name | First Name

Social Security Number | Date of Birth

Relationship: O Spouse O Child | Gender: O Female O Male

Dependent Status: O Disabled | If disabled, indicate reason:

Dependent Information

Last Name | First Name

Social Security Number | Date of Birth

Relationship: O Spouse O Child | Gender: O Female O Male

Dependent Status: O Disabled | If disabled, indicate reason:

Dependent Information

Last Name | First Name

Social Security Number | Date of Birth

Relationship: O Spouse O Child | Gender: O Female O Male

Dependent Status: O Disabled | If disabled, indicate reason:

Dependent Information

Last Name | First Name

Social Security Number | Date of Birth

Relationship: O Spouse O Child | Gender: O Female O Male

Dependent Status: O Disabled | If disabled, indicate reason:

Signature needed whether applying for coverage OR waiving

Employee or legal representative signature: ______________________ Date: ____________

AMPM STAFFING SERVICES

Outline of Proposed Benefits
Effective 11/01/2014

Humana - Medical and Prescription Drugs

www.humana.com

Services	NPOS HDHP 14		NPOS 14 COPAY	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible **- Individual** **- Family**	$5,000 $10,000	$15,000 $30,000	$4,000 $8,000	$12,000 $24,000
Coinsurance	80%	60%	80%	50%
Out-of-Pocket Max **- Individual** **- Family**	*(Includes the deductible and the coinsurance)* $6,000 $12,000	$18,000 $36,000	*(Includes the deductible, coinsurance and co-pays)* $6,250 $12,500	$18,000 $36,000
Physician Office Visit	Deductible then 20%	Deductible then 40%	$40 co-pay	Deductible then 50%
Specialist Office Visit	Deductible then 20%	Deductible then 40%	$55 co-pay	Deductible then 50%
Urgent Care	Deductible then 20%	Deductible then 40%	$100 co-pay	Deductible then 50%
Emergency Room	Deductible then 20%	Deductible then 40%	$250 co-pay	Deductible then 50%
Inpatient Hospital Care	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 50%
Outpatient Facility	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 50%
Prescription Drugs	Deductible then 20%		$10/ $35 / $55 / 25%	

Bi-Weekly Cost	NPOS HDHP 14		NPOS 14 COPAY	
	Employee Cost	AMPM Cost	Employee Cost	AMPM Cost
Employee Only	**$55.00**	**$135.00**	**$129.08**	**$135.00**
Employee & Spouse	**$245.03**	**$135.00**	**$393.15**	**$135.00**
Employee & Children	**$226.02**	**$135.00**	**$366.75**	**$135.00**
Employee & Family	**$473.04**	**$135.00**	**$710.05**	**$135.00**

Note: These premiums are approximate and subject to change..