# 2024 Team Member Election of Associate Plan Menu and Contributions

☐ New Hire ☐ Life Event ☐ Open Enrollment

Associate Name: ____ #300 Number: ____

Social Security Number: ____ Date of Birth: ____

Home Address: ____

City: ____ State: ____ Zip: ____

Signature: ____ Date: ____

## APCN Plus

**Basic Managed Care Plan (Bronze)**

Associate Contributions (Weekly)

☐ Team Member Only: **$3.14**

☐ Team Member + Family: **$10.28**

**Managed Care Plan (Silver Plus)**

Associate Contributions (Weekly)

☐ Team Member : **$25.41**

☐ Team Member + Family: **$67.38**

**HCRA Plan**

Associate Contributions (Weekly)

☐ Team Member Only: **$7.31**

☐ Team Member + Family: **$18.84**

**Premium Managed Care**

Associate Contributions (Weekly)

☐ Team Member Only: **$46.82**

☐ Team Member + Family: **$127.90**

## Broad Network

**Basic Managed Care Plan (Bronze)**

Associate Contributions (Weekly)

☐ Team Member Only: **$3.38**

☐ Team Member + Family: **$11.06**

**Managed Care Plan (Silver Plus)**

Associate Contributions (Weekly)

☐ Team Member Only: **$27.34**

☐ Team Member + Family: **$72.50**

**HCRA Plan**

Associate Contributions (Weekly)

☐ Team Member Only: **$7.87**

☐ Team Member + Family: **$20.27**

**Premium Managed Care**

Associate Contributions (Weekly)

☐ Team Member Only: **$50.38**

☐ Team Member + Family: **$137.62**

☐ **Medical Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

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Price Rite MARKETPLACE

Team Member Name:

**Dental: MetLife Dental Plan**

Associate Contributions (Weekly)

- ☐ Team Member Only: **$1.29**
- ☐ Team Member + Family: **$3.67**
- ☐ **Dental Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

**Vision: EyeMed Vision Plan**

Associate Contributions (Weekly)

- ☐ Team Member Only: **$0.00**
- ☐ Team Member + One Eligible Dependent: **$2.64**
- ☐ Team Member + Family: **$2.92**
- ☐ **Vision Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

Associate Hire Date:

Effective Date:

Effective Date Notes:

Billing Store:

Additional Notes:

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Price Rite MARKETPLACE

Team Member Name:

## Dependent Enrollment

Please attach applicable Marriage Certificate/Birth Certificate for anyone you are adding.

Name: Date of Birth: Relationship: SSN:

**Medical** ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:

**Medical** ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

Name: Date of Birth: Relationship: SSN:

**Medical** ☐ Add ☐ Drop **Dental** ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

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