KLB
Kingdom Legacy Benefits

Employee Form

Section 1. Employee Information

Effective Date / /

Full Name | Date of Birth | Date of Hire | Social Security Number - -

Home Address | City | State | Zip Code

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Domestic Partner

Place of work | Phone Number

Pre-tax ☐ Post-tax ☐

Section 2. Qualifying Events

☐ New Enrollment
☐ Open Enrollment
☐ Change in Enrollment
☐ Adding Dependent(s)
☐ Deleting Dependent(s)
☐ COBRA Continuation

Qualifying Event Type

☐ Birth, Adoption, Etc.
☐ Gained Coverage
☐ Loss Coverage
☐ Married
☐ Divorced
☐ Other _____

Section 3. Coverage Election Medical

☐ Plan 1 - U.S

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

☐ Plan 2 - U.S / Mexico

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

(A)dd (C)hange (D)Delete	Relationship	Full Name	Social Security Number	Date of Birth	Gender
	Self		- -		
	☐ Spouse ☐ Domestic Partner		- -		
	Child 1		- -		
	Child 2		- -		
	Child 3		- -		
	Child 4		- -		

Section 4. Declination Of Coverage (Complete this section ONLY if declining coverage for yourself OR eligible dependents)

DECLINE (Check all that apply and give reason)
☐ Self
☐ Spouse / Domestic Partner
☐ Child (ren)

REASON
☐ Have Other Group Coverage
☐ Have Other Individual Coverage
☐ Other _____

Applicant Signature _____ Date / /

Section 5. Employee Signature

PLEASE READ PRIOR TO SIGNING – I accept the insurance provided by the Plan Sponsor and authorize the deductions in my earnings of the contribution required, if any, toward the cost of the premiums. I understand that if the prior information is not complete or is incorrect, this coverage may be terminated retroactively. I authorize each salary payroll to be reduced on a pre-tax basis in accordance with the indicated elected benefits.

MEC plans and LBMP plans generally cover preventative and wellness related tests and treatments. While they meet certain requirements outlined under the affordable care act (ACA) and ERISA, they are not what most think of as traditional health insurance. This plan does not meet the Minimum Value criteria as defined by (ACA) for the employer mandate.

Applicant Signature _____ Date / /