south cove
community health center
華人醫務中心

Group Medical Insurance Choice Selection

Employee contributions listed below will be effective **07/01/2022**.

Deductions are applied twice per month.

Tufts Health Plan – HMO Advantage

Please select a plan from one of the options below and complete box 3 OR complete the Waiver of Medical Coverage section

Option 1 50217-000: Deductible $1,000 Individual; $2,000 Indiv+1/Family

Scheduled Hrs per wk	Individual	Individual+1	Family
>= 32 hrs	$70.94 _____	$255.22 _____	$390.85 _____
>= 24 hrs and < 32 hrs	$166.91 _____	$418.21 _____	$603.15 _____

Option 2 50806-000: Deductible $2,500 Individual; $5,000 Indiv+1/Family

Scheduled Hrs per wk	Individual	Individual+1	Family
>= 32 hrs	$29.49 _____	$180.49 _____	$291.63 _____
>= 24 hrs and < 32 hrs	$125.46 _____	$343.48 _____	$503.93 _____

I understand that this selection form does not replace the enrollment form which may be required for any group plan listed and that coverage is not assured until all requirements of the insurance company have been satisfied. Furthermore, I certify that I have been presented with the specifics of any of the plan information for which I am enrolling and understand the terms and conditions. I also understand that an incomplete enrollment application may delay or prohibit coverage. Where applicable, employee contributions will be deducted on a pre-tax bases, unless indicated otherwise.

Employee Signature _____ Date: _____

Employee Name (Print) _____

Waiver of Medical Coverage

I waive my option to be covered under the group medical plan at this time because I have coverage through a different source. I understand that I may enroll under this plan in the future ***only if*** one of the following conditions apply:

1. I have a qualifying life event (i.e. marriage, divorce, birth/adoption of a child, etc…)
2. During the next annual open enrollment period

I currently have coverage through (*must indicate one*):

_____ My spouse's employer *(Proof of coverage must be provided to South Cove Community Health Center)*

_____ Another source *(Proof of coverage must be provided to South Cove Community Health Center)*

Employee Signature _____ Date: _____

Employee Name (Print) _____

Complete and return this form to Human Resources along with the enrollment application (if any).

Revised 06/01/2022