EMPLOYEE BENEFIT PLAN
OPEN ENROLLMENT AND CHANGE FORM

(Please fill out this form completely.
All information is necessary for proper enrollment.)

(HR Use ONLY):
EMPLOYMENT DATE: ______/______/__________ OR
DATE CHANGED FROM PART-TIME TO FULL-TIME: ___/___/___
[Does the regular waiting period apply? Refer to Plan Document. ___ yes or ___ no]
EFFECTIVE DATE: ________/_______/___________

BURRITO CONCEPTS, LLC | **010117BC** | LOCATION CODE (HR Use ONLY): | SEX: ___ M ___ F | DATE OF BIRTH:

EMPLOYEE LAST NAME: (Mark this box for name change. □) | FIRST NAME: | M.I. | SOCIAL SECURITY NUMBER:

STREET ADDRESS: (Mark this box for address correction. □) | CITY/STATE/ZIP: | HOME PHONE NUMBER: ( )

ENROLLMENT TYPE:
___ FIRST TIME ELIGIBLE AFTER WAITING PERIOD
___ SPECIAL ENROLLMENT
___ OPEN ENROLLMENT

TERMINATION EVENT (HR Use ONLY):
Divorce ___/___/___, Loss of Employment ___/___/___,
Death ___/___/___, Other: ______________ ___/___/___

MARITAL STATUS:
____ SINGLE ____ DIVORCED ____ WIDOWED
____ MARRIED (Date of current marriage _________)

SPECIAL ENROLLMENT EVENT (*One of these events must have occurred in the past 30 days in order to qualify for Special Enrollment. Otherwise, enrollment must be made during the open enrollment period for an effective date of January 1st.*):
Marriage ____________, Birth _____________, Placement for Adoption of Legal Guardianship _______________, Adoption ________________,
Loss of Other Coverage ________________, Loss of Medicaid Coverage ______________ (within last 60 days), COBRA to Active Coverage ___________.
Notes regarding special enrollment: ____

1) Medical Plan: __ Employee __ Employee & Spouse __ Employee & Child(ren) __ Employee & Family ___ Decline

2) Unreimbursed Healthcare Expenses FSA Plan:

_ I **elect** to contribute $________ per pay period to fund my account for reimbursement of qualified out-of-pocket healthcare expenses not covered under my health and other insurance plans. (Maximum amount per calendar year is $2,650.)
_ I **decline** to participate in this option for this plan year.

Please AUTO PROCESS the following claim types under my FSA Plan: (If you have other insurance that will be filed you may not elect this option)

____ **Medical** (No need to file claims for anything that will be filed to Med-Pay by the provider.)
____ **Prescription** (No need to file claims for your copays.)

3) Dependent Care Assistance FSA Plan:

_ I **elect** to contribute $__________ per pay period to fund my account for reimbursement of qualified dependent daycare expenses. (Maximum amount per calendar year is the lesser of; (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3) 1/2 of your total annual compensation. If you are single, the maximum amount is $5,000.)
_ I **decline** to participate in this option for this plan year.

You may set up direct deposit for reimbursement of your FSA claims. Log in: https://hrbenefitsdirect.com/med-pay

NOTE: **You must complete the Other Health Insurance (OHI) section of this form to disclose OHI coverage either as an employee or dependent of another health plan (employer group plan, Medicare, Medicaid). Claims processing will be delayed if this information is not on file. Please attach dependent eligibility documents (i.e., marriage license, birth certificates) for enrollment of newly eligible dependents. These documents are required before claims can be processed.**

For newly eligible persons: Indicate an "A" for ADDITION. When submitting a change, indicate an "A" or "T" (TERMINATION).

A/T	Last Name First Name M.I.	Relation Code (See below)*	Male or Female	Date of Birth	Social Security Number	Disabled? (Need letter from Physician.)
	Spouse:	SP				
	Does Spouse's employer offer group health coverage? __ YES __ NO. Is spouse eligible for that coverage? __ YES __ NO. Is spouse enrolled under that coverage? __ YES __ NO.					
	Child:					
	Child:					
	Child:					
	Child:					
	Child:					
	Child:					

Attach additional forms if necessary.

* **Relationship =** child (CH), step-child (SC), adopted child (AD) and under employee's legal guardianship (LG). Grandchildren are only eligible if the Employee is the Legal Guardian. Foster Children may not be eligible under the Plan. Refer to the Plan Document for criteria and documentation required.

I authorize the preceding enrollment application or change(s) of enrollment for myself and any eligible members of my family listed above. I authorize my employer to make the applicable change in my payroll deduction based upon my election or declination of coverage for this Plan(s). This Plan has a Coordination of Benefits provision which I understand will be adhered to before any benefits are payable. I understand I am required to notify my employer of any situations that may affect coverage status. This includes a newborn child. I further authorize anyone providing services to me or my dependents to release to this Plan(s) any information or medical records relating to those services. I certify that all information contained in this form is true and complete to the best of my knowledge. If I am *declining* coverage in the Employee Benefit Plan, I understand that myself and/or my dependents may only request coverage at a later time if there is an applicable HIPAA Special Enrollment event or it is open enrollment. Refer to the plan document(s) for eligibility/enrollment criteria.

Signature: Date signed:

Return these forms to your HR/Benefits Office.
(Continued on page 2- OHI Form- Employee/Spouse)

OTHER HEALTH INSURANCE (OHI) INFORMATION FORM

(This only needs to be completed if you have Spouse and/or Dependent Children covered under this plan.)

Other **H**ealth **I**nsurance (OHI) coverage is medical coverage through an employer-sponsored group plan and/or Medicare or Medicaid under which the member is covered either as an employee, retiree or dependent. Please fully complete the information below to identify whether or not you or any family member covered under this Employer's Plan has medical coverage through one of these types of plans.

If this form is not completed and returned, claims will be pended until this information is received.

Group Name: BURRITO CONCEPTS, LLC			**Group Number: 010117BC**
EMPLOYEE	LAST NAME:	FIRST NAME:	M.I.:
Do you, as an employee of Burrito Concepts, LLC have any other health coverage in addition to this employer policy? ____________YES __________NO			
Phone number: (H) __________________________ (C) ___________________________		Social Security Number:	Date of Birth:

SPOUSE	LAST NAME:		FIRST NAME:		M.I.:		
Phone number: (H) __________________________ (C) ___________________________				Social Security Number:	Date of Birth:		
OHI: ___Yes ___ No		If yes, please provide the following information:	OHI Policy Holder Name:		Policy Holder's Date of Birth:		
OHI Policy Holder relation to Employee:	__Self, ___Spouse, __ Parent, __Other (_____)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA		*OHI Effective Date (If Medicare, include Part A & B dates):		
If Medicare coverage, reason for coverage:		___ Over 65 ___ Disabled ___ End Stage Renal Disease ___ Other ___________________					
OHI Policy Holder's Employer:		Group Number:		Policy ID Number:			
OHI Policy Holder's Address:							
OHI Carrier Name, Address & Phone Number:							

CHILD	LAST NAME:	FIRST NAME:		Date of Birth:	
Relation to Employee: __Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship					
Child's Address if different than Employee's:					
OHI: ___Yes ___ No	OHI Policy Holder Name:			Policy Holder's Date of Birth:	
OHI Policy Holder relation to Dependent:	__Self, __ Parent, __Spouse, __Other (___________)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage: ___ Disabled ___ End Stage Renal Disease ___ Other ___________________					
OHI Policy Holder's Employer:	Group Number:	Policy ID Number:		OHI Carrier Name & Phone Number:	
**If the Child's Parents are __Separated, __Divorced or __Never Married				Who has physical custody?	
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					
Mother's Name, Address & Phone No.:					
Father's Name, Address & Phone No.:					

* Please attach a copy of the ID card for any other insurance plans.

** If "yes", please attach/send a copy of the following portions of the separation agreement/divorce decree: a) the first page which identifies the petitioner and respondent; b) any pages that reference custody and insurance; and c) the judge's signature page (usually the last page of the document). Note: Please be sure to include these same pages for any attachments (i.e., parenting plan, separation agreement, etc.) that is referenced in the decree.

Please return these OHI forms with your enrollment form to your HR/Benefits Office. Thereafter, please notify Med-Pay immediately if any of this information changes, (417) 886-6886 or (800) 777-9087.

____ ____________________

Employee Signature Date

(Continued on page 3- OHI Form- Dependent Children)

OTHER HEALTH INSURANCE (OHI) INFORMATION FORM
(DEPENDENT CHILDREN)

Other **H**ealth **I**nsurance (OHI) coverage is medical coverage through an employer-sponsored group plan and/or Medicare or Medicaid under which the member is covered either as an employee, retiree or dependent. Please fully complete the information below to identify whether or not you or any family member covered under this Employer's Plan has medical coverage through one of these types of plans.
If this form is not completed and returned, claims will be pended until this information is received.

Group Name: BURRITO CONCEPTS, LLC			Group Number: 010117BC
EMPLOYEE LAST NAME:	FIRST NAME:	M.I.	SOCIAL SECURITY NUMBER:

CHILD	LAST NAME:	FIRST NAME:	Date of Birth:

Relation to Employee: __Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship

Child's Address if different than Employee's:

OHI: ___Yes ___ No	OHI Policy Holder Name:	Policy Holder's Date of Birth:

OHI Policy Holder relation to Dependent: __Self, __ Parent, __Spouse, __Other (___________)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	

If Medicare coverage, reason for coverage: ___ Disabled ___ End Stage Renal Disease ___ Other __________________

OHI Policy Holder's Employer:	Group Number:	Policy ID Number:	OHI Carrier Name & Phone Number:

**If the Child's Parents are __Separated, __Divorced or __Never Married	Who has physical custody?
OHI Policy Holder's Address:	
OHI Carrier Name, Address & Phone Number:	
Mother's Name, Address & Phone No.:	
Father's Name, Address & Phone No.:	

CHILD	LAST NAME:	FIRST NAME:	Date of Birth:

Relation to Employee: __Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship

Child's Address if different than Employee's:

OHI: ___Yes ___ No	OHI Policy Holder Name:	Policy Holder's Date of Birth:

OHI Policy Holder relation to Dependent: __Self, __ Parent, __Spouse, __Other (___________)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	

If Medicare coverage, reason for coverage: ___ Disabled ___ End Stage Renal Disease ___ Other __________________

OHI Policy Holder's Employer:	Group Number:	Policy ID Number:	OHI Carrier Name & Phone Number:

**If the Child's Parents are __Separated, __Divorced or __Never Married	Who has physical custody?
OHI Policy Holder's Address:	
OHI Carrier Name, Address & Phone Number:	
Mother's Name, Address & Phone No.:	
Father's Name, Address & Phone No.:	

If necessary, make copies and attach additional pages of this OHI Form for more dependent children.

* Please attach a copy of the ID card for any other insurance plans.

** If "yes", please attach/send a copy of the following portions of the separation agreement/divorce decree: a) the first page which identifies the petitioner and respondent; b) any pages that reference custody and insurance; and c) the judge's signature page (usually the last page of the document). Note: Please be sure to include these same pages for any attachments (i.e., parenting plan, separation agreement, etc.) that is referenced in the decree.

Please return these OHI forms with your enrollment form to your HR/Benefits Office. Thereafter, please notify Med-Pay immediately if any of this information changes, (417) 886-6886 or (800) 777-9087.

____ ________________________
Employee Signature Date