

EMPLOYER OPEN ENROLLMENT SUMMARY

IMPORTANT: This form must be completed and returned whether the group is making benefit changes or not.

Legal Name of Employer	Federal Tax ID No.
Name of Broker/Agent	

EMPLOYEE PARTICIPATION

AOI HealthChoice requires that 100% of all eligible employees for groups of 2-10 and 75% of all eligible employees in groups of 11 or more must participate. Individuals who waive coverage due to other group coverage are not included in the calculation.

Step 1		Total number of eligible employees (Include number of employees who waived coverage)	_____	(1)
Step 2	Less	Number of employees who waived due to other group coverage	-	_____ (2)
Step 3		Adjusted eligible employees	=	_____ (3)
Step 4	Equals	Total number of employees enrolled in AOI HealthChoice		_____ (4)
Step 5		Participation percentage (step 4 ÷ step 3)		_____ (5)

EMPLOYER PREMIUM CONTRIBUTION (DETAIL % OR \$ AMOUNT)

Employee _____ Employee+Spouse _____ Employee+Child(ren) _____ Family _____

SELECTION OF COVERAGE

PLEASE CHOOSE ONE OF THE BENEFIT PACKAGES SHOWN BELOW:

AOI HealthChoice Benefit Packages

Please indicate choice of carrier:

Kaiser: All plans include RX

HMO 15 HMO 20
 HMO 250 HMO 500
 HMO 1000 HSA 2600

 Kaiser Vision

Please see renewal packet or for explanation of package benefits.

All enrollment forms and benefit summaries can be found online at <http://aoihc.aoi.org>.

SELECTION OF ADDITIONAL BENEFITS

Vision Coverage		Dental Coverage*	
<input type="checkbox"/> Yes, I would like to elect Vision coverage	<input type="checkbox"/> No, I choose not to elect Vision coverage at this time	<input type="checkbox"/> Yes, I would like to elect Dental coverage (choose level): <input type="checkbox"/> Preferred Option <input type="checkbox"/> Standard Option <input type="checkbox"/> Value Option	<input type="checkbox"/> No, I choose not to elect Dental coverage at this time

*Employer must provide proof of 24 months of prior dental coverage to elect the Standard or Preferred Options. Employees may indicate their choice of dental carrier on their medical enrollment form.

I hereby acknowledge that the AOI HealthChoice annual open enrollment has been completed. During the open enrollment all eligible employees were given the opportunity to:

- Enroll in the plan if coverage was previously waived,
- Waive coverage if previously enrolled,
- Enroll eligible dependents,
- Change medical carrier, or
- Change dental carrier.

If you choose not to continue your coverage with AOI HealthChoice, please make a notation here:

Please cancel my coverage through AOI HealthChoice. I choose not to renew.

If you choose not to continue your medical coverage with AOI HealthChoice, but would like to enroll in dental only, please make a notation here:

Please cancel my medical coverage through AOI HealthChoice, but add or continue my group dental coverage as indicated on the attached employee enrollment forms.

Employer Representative Signature

Date

Employer Representative Title

NOTE: This form must be completed for all groups in their open-enrollment period, whether renewing or not. Please return this form and any other renewal materials to: AOI HealthChoice, PO Box 22389, Portland, OR 97269. This form may also be faxed to (503) 968-2817.