SIHRA Enrollment Form

EMPLOYER INFORMATION

Employer Name: Laitram

Please mail, e-mail or fax completed form to:

Catilize Health
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

Email: memberservices@catilizehealth.com
Telephone: 877-872-4232
Toll Free Fax: 877-599-3724

I am enrolling in the SIHRA for (Please check one): ☐Self Only ☐Self & Child(ren) ☐Child(ren) Only ☐Spouse Only ☐ Self & Spouse ☐Self & Family ☐Spouse & Child(ren)

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: ☐M ☐F	Date Eligible for SIHRA:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: ☐M ☐F
Social Security No:	Spouse's Employer:	

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		

PARTICIPANT AUTHORIZATION

* If the other coverage is a HDHP and your spouse is not enrolled in the SIHRA, your spouse may contribute to the HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the SIHRA. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by the SIHRA. Also, if your primary health coverage is through Medicare, Tricare, VA health care, or Medicaid, you are not eligible for the SIHRA.

I hereby authorize my employer to enroll me into the employer sponsored SIHRA. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for SIHRA benefits.

Employee Signature: **Date:**

CONFIRMATION OF ENROLLMENT
IN A NON-LAITRAM EMPLOYER GROUP HEALTH PLAN

Employee Name: _____ Phone: _____

Email:_____

This form applies to individuals who participate in Laitram's SIHRA plan and who waive coverage in Laitram's health plan.

The employee, spouse, and/or dependent(s) listed below waive coverage in the Laitram health plan and understand that:

-- Laitram has offered me and/or my spouse and/or my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

Excepted Benefits are those not typically included in traditional health insurance plans such as (i) non-health coverage (e.g. workers' compensation and disability insurance), (ii) limited health benefits (e.g. dental and vision insurance), or (iii) specific disease/illness insurance (e.g. cancer or hospital indemnity insurance).

-- I and/or my spouse and/or my eligible dependents are enrolled in alternate coverage (such as my spouse's employer) that does not consist solely of "excepted benefits" under the ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).

-- I understand and acknowledge that by enrolling in Laitram's SIHRA plan, I waive participation in the Laitram health plan for the following participants:

_____ _____
Name Name

_____ _____
Name Name

Attach a separate sheet if space is needed for additional participants

To confirm your alternate coverage meets the IRS's definition of minimum value and does not consist solely of a Health Reimbursement Arrangement, please contact the benefits coordinator for the employer providing the alternate coverage.

I confirm that the alternate coverage is not:

- A High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, **it is acceptable alternate coverage** if contributions can be waived. A spouse who is not enrolled in the SIHRA may contribute to an HSA and use the HSA funds.
- The HSA funds CANNOT be used for medical expenses for members enrolled in the SIHRA.
- Medicare, Tricare, VA health care or Medicaid
- Health Insurance coverage made available thru the Affordable Care Act
- An individual policy or Limited Benefit Health Plan
- Coverage through another Laitram employee

_____ _____
Employee Signature Date

_____ _____
Spouse's Signature ONLY IF ELIGIBLE FOR SIHRA Date

For more information, please contact Catilize Health @ 877-872-4232

PLEASE COMPLETE THIS FORM AND SEND TO CATILIZE HEALTH VIA FAX, EMAIL OR MAIL:

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