HOPE TRUST
Health Options for Public Entities

FORM A
Must be Completed by **EVERY** Employee
Due to the County Board Office 10/28/2022

Employer Record of Enrollment Offer

EMPLOYER SHOULD RETAIN COMPLETED FORM FOR RECORDS

ALREADY ENROLLED (NO CHANGES)

I am already enrolled along with any of my selected dependents (if applicable) in the HOPE Trust Health Care Plan and do not wish to add any additional dependents at this time *or* change my plan selection for the next plan year. This enrollment shall remain in effect until my employer is notified by me to the contrary or until coverage is terminated in accordance with plan provisions.

Employee Name (Print): _____

Employee Signature: _____ **Date Signed:** _____

ACCEPT (OR CHANGE PLAN)

I accept the opportunity to enroll myself and my selected dependents (if applicable) *or* to add additional dependents *or* to change my plan selection for the next plan year in the HOPE Trust Health Care Plan and at the prevailing cost (if any) required for participation. This enrollment shall remain in effect until my employer is notified by me to the contrary or until coverage is terminated in accordance with plan provisions.
*** (Additional **Employee Enrollment Form** must be completed.) ***

Employee Name (Print): _____

Employee Signature: _____ **Date Signed:** _____

DECLINE

I DO NOT WISH TO ENROLL myself or my selected dependents in the HOPE Trust Health Care Plan at this time and understand the option to enroll at any future time will be limited to special enrollment opportunities or during open enrollments as provided under the terms of the HOPE Trust Health Care Plan.

Employee Name (Print): _____

Employee Signature: _____ **Date Signed:** _____

EMPLOYER USE ONLY -- ENROLLMENT OFFERED FOR:

_____ New Hire/New Full-Time (FT Hire Date: _____)
_____ Special Enrollment (Event: _____)
_____ Open Enrollment (MM/YYYY): _____/_____