Nicholas Markets
2024 Associate Benefit Enrollment
Associate Plan Menu and Contributions

☐ New Hire ☐ Life Event ☐ Open Enrollment

Associate Name: ____________ #300 Number: ____________

Social Security Number: ____________ Date of Birth: ____________

Home Address: ____________

City: ____________ State: ____________ Zip: ____________

Signature: ____________ Date: ____________

ACO Network

Aetna Whole Health

Basic Managed Choice Plan (Bronze)
Associate Contributions (Weekly)

☐ Associate Only: **$41.94**
☐ Associate + Family: **$111.72**

Managed Choice Plan (Silver Plus)
Associate Contributions (Weekly)

☐ Associate Only: **$77.07**
☐ Associate + Family: **$205.25**

HCRA Plan (Aetna Healthfund)
Associate Contributions (Weekly)

☐ Associate Only: **$68.24**
☐ Associate + Family: **$181.73**

Broad Network

Basic Managed Choice Plan (Bronze)
Associate Contributions (Weekly)

☐ Associate Only: **$44.74**
☐ Associate + Family: **$119.18**

Managed Choice Plan (Silver Plus)
Associate Contributions (Weekly)

☐ Associate Only: **$82.21**
☐ Associate + Family: **$218.96**

HCRA Plan (Aetna Healthfund)
Associate Contributions (Weekly)

☐ Associate Only: **$72.79**
☐ Associate + Family: **$193.87**

☐ **Medical Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

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Associate Name:

Vision: EyeMed

EyeMed Vision Plan: Option 1
Associate Contributions (Weekly)

- ☐ Associate Only: **$0.73**
- ☐ Associate + One Eligible Dependent: **$1.38**
- ☐ Associate + Family: **$2.03**

EyeMed Vision Plan: Option 2
Associate Contributions (Weekly)

- ☐ Associate Only: **$1.17**
- ☐ Associate + One Eligible Dependent : **$2.34**
- ☐ Associate + Family: **$3.75**

☐ **Vision Waiver:** Since I have refused the insurance, I understand that I may not enroll in my employer's plan until the next open enrollment period unless I have a qualifying life event, such as marriage, death of a spouse, birth, adoption, a court has ordered coverage to be provided for a spouse or minor child or lose my coverage elsewhere. If I experience a qualifying life event, I understand that I must request enrollment in the plan within thirty (30) days of the qualifying life event.

For administration use only.

Associate Hire Date: Effective Date:

Effective Date Notes:

Billing Store:

Additional Notes:

November 2023

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Associate Name:

Dependent Enrollment

Please attach applicable Marriage Certificate/Birth Certificate for anyone you are adding.

Name: Date of Birth: Relationship: SSN:
Medical ☐ Add ☐ Drop **Vision** ☐ Add ☐ Drop

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