New Employee Checklist

HOLLY RIDGE QUALITY
CHILDCARE & PRESCHOOL
502 US-17 HOLLY RIDGE, NC 28445
HRQualityChildcare.COM
(910) 803-3003

Before employment:

1. **Fill out application. Do not leave any blanks.**
2. Go to https://ncchildcare.ncdhhs.gov/
   - **Click on the Criminal Background Check Portal.**
   - **Click on the Application** (bottom right of the screen).
   - **Click- "Click here to get an NCID"**
     - Register for an Individual NCID
   - Then go back to The Criminal Background Check Portal and Apply using your new NCID and password.
   - You should receive an email when you are PROVISIONAL OR QUALIFIED and will be asked to log in to your NCID account to print the letter.
3. **Use the LiveScan Fingerprinting service provided by Onslow County Sheriff's Department on Tuesday/Thursday from 8-11 am and 2-4 pm located at 206 Marine Blvd. Jacksonville (910) 455-1472**
   - Be sure to bring identification (picture ID) and **electronic fingerprint release** (from step 2). Be sure the official signs it.
   - Make sure to bring cash to pay for prints. They may not take credit cards or checks.
4. **Go to the doctor** complete the TB test and Medical Report. Results need to be received by our facility **prior to employment.**

On or before your first day of work, bring and/or complete:

- **CBC Provisional or Qualification Letter (cannot start without this)** https://ncchildcare.ncdhhs.gov/
- **Negative result TB test and Medical Report (cannot start without this)**
- Picture ID and social security card
  - A copy of both are required for your I-9 form
- Emergency and Health Questionnaire forms completed
- Orientation will begin
  - 6 hours are required within the first two weeks of employment
  - Remaining within the first six weeks of employment
- Receipt of job description signed
- Receipt of Employee policies and benefits signed
- Tax information W-4 & NC-4
- A voided check or checking account information for payroll direct deposit

Within first 6 weeks of employment:

- Must receive CPR and First Aid training (full online course is not eligible for childcare).
- NCRLAP.org Training Videos for instruction on best practice.
- **Complete the Health and Safety Training required by NCDCDEE MOODLE (using your newly created NCID and password to log in) https://www.dcdee.moodle.nc.gov/**
  - **Log in**
  - **Click on "My Courses"**
  - **Search for and enroll in** *"CCDF Health and Safety in Child Care" and "Part 1: Medications in Child Care"* **to take these trainings.**
  - **Print or email certificates to HRQCC@outlook.com**
- ****Due by 6th week of employment** Take the Recognizing and Responding to Child Abuse and Neglect Training https://preventchildabusenc-lms.org/**
  - This is a 3rd party site and will required a new username and password

Application for Employment

Date of Application _____

Please Print (Fully complete both pages)

Last four digits of SSN	Last Name	First Name	Middle Name

Address (street number and name)	City	County

State	Zip Code	Phone (home or where you can be reached)	Business Phone

Position Applied For:_____Email:_____

Date of Birth: _____ N. C. Driver's License Number_____
(month) (day) (year)

Have you ever been convicted of breaking a law other than a minor traffic violation? YES____ NO____ If yes, give the date and explain fully. Use an additional piece of paper if more space is needed:_____

_____

Have you ever had an abuse or neglect or child maltreatment substantiation? YES____ NO____ If yes, list county/State and give the date and explain fully. Use an additional piece of paper if more space is needed:_____

_____

(The offense(s) and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

Education

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4

Schools	Name and Location	Dates Attended	Coursed of Study	Degree/Diploma
High School				
		to		
College or University		to		
		to		
		to		
		to		
Graduate or Professional				
Educational, Vocational Schools, etc.				

Child care training completed in the last three years (such as First Aid, CPR, Health and Safety Training, ITS-SIDS, CDA etc.):

_____

References

List the names, addresses, and phone numbers of people we may contact as references:

_____

_____

_____

Work History

(List child care/early childhood experience first.)

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

I certify that I have given true, accurate, and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration, and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigations of all statements made in this application and understand that false information of documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action, or dismissal if I am employed, and (or) criminal action. I further understand that dismissal on unemployment shall be mandatory if fraudulent disclosures are given to meet position qualifications.

Signature of Applicant_____ Date_____

Health Questionnaire – Child Care Centers

10A NCAC 09 .0701(a)

All staff, including the director, must complete a health questionnaire annually following the initial medical report. Substitute providers and volunteers must complete a health questionnaire on or before the first day of work and annually thereafter.

Full name of individual:	
Home address:	
Phone number:	Email:

I certify that I am emotionally and physically fit to care for children.

Signature:
Date:

This portion of the form to be completed by the Child Care Center Director

As the director, I understand that I may request another evaluation of a staff member's emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member's emotional or physical fitness to care for children. This request may be made based upon factors such as observations of myself or other staff members, reports of concern from family, reports from law enforcement, or reports from medical personal. Child Care Rule 10A NCAC 09 .0701(b).

Director's Signature:
Date:

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d)

Emergency Information – Staff

10A NCAC 09 .0701(a)

Child care providers, including the director, uncompensated providers, substitute providers, and volunteers must provide this information on or before the first day of work. Emergency information must be updated as changes occur and at least annually.

Date completed:	
Full name of individual:	
Home address:	
Phone number:	Email:

Person(s) to be contacted in case of an emergency:

Primary contact
Name:
Address:
Phone number:
Secondary contact
Name:
Address:
Phone number:

Choice of health care professional:
Address:
Telephone number:

Staff Health Assessment/Medical Report

10A NCAC 09 .0701 (Child Care Centers)

This document, completed by a health care professional prior to employment, indicates that the individual listed is emotionally and physically fit to care for children. This form must have been completed within the last twelve months.

Full name of individual:	
Home address:	
Phone number:	Email:

To be completed by a health care professional

Date of assessment:
Does this applicant have any physical condition that would limit their ability to work with children? ☐ Yes ☐ No If yes, please describe:
Is this applicant currently under treatment that would limit their ability to work with children? ☐ Yes ☐ No If yes, please describe:
Is this applicant currently taking any medication that would affect his/her work with children? ☐ Yes ☐ No If yes, please describe:
In your opinion, is this applicant emotionally and physically capable to care for children on a daily basis? ☐ Yes ☐ No

Name of health care professional:	Date:
Signature of health care professional:	
Address:	
Phone number:	

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d).

Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, operators, additional caregivers, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

Last name (print clearly)	First name	Middle	Date of Birth

Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	**YES**	**NO**
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?	**YES**	**NO**
5) Have you ever been exposed to anyone with infectious tuberculosis?	**YES**	**NO**

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?		
1) Unexplained cough lasting more than 3 weeks?	**YES**	**NO**
2) Unexplained fever lasting more than 3 weeks?	**YES**	**NO**
3) Night sweats (sweating that leaves the bedclothes and sheets wet)?	**YES**	**NO**
4) Shortness of breath?	**YES**	**NO**
5) Chest pain?	**YES**	**NO**
6) Unintentional weight loss?	**YES**	**NO**
7) Unexplained fatigue (very tired for no reason)?	**YES**	**NO**

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:	Date:

Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

Record of Tuberculosis Test

Last name (print clearly)	First name	Middle	Date of birth

Type of test:

☐ Tuberculin

Date given	
Date read	
Results	MM reading: _____ ☐ Negative ☐ Positive

☐ Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

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Behavior Management Policies

Effective: August 29, 2022

All students are to be held by lifting under their arms using both hands and raised vertically. Student should be placed facing the adult or in such a manner they engaged to begin assisted self-soothing or positioned to de-escalate their distressed state. Student should be comfortable and unrestricted in this position. If a staff member is unable to carry a student using this method due to medical issues, another staff member will be appointed. No child above the age of three will be held if they show signs of distress by flailing extremities, throwing themselves backwards, or attempting to physically injure themselves or others.

To address children younger than three years of age: When a student is in a state of physical, emotional, or social distress in which they are unable to self-sooth, a staff member will console them with methods deemed appropriate by DHHS when soothing infants and toddlers. The students will be carried, consoled, and/or rocked. If the child continues to be distressed after a reasonable amount of time, administration will be radioed. A determination to inform parents/guardians will be made.

To address children ages three and older within HRQCC care: When a student is in a state of distress in which they are actively injuring themselves or others, staff will remove the other students from the space and radio for assistance from administration. An appointed staff member will stay with distressed student and another with the remaining students.

The staff member assigned to the distressed student will remove obstructions in order to avoid further injury. In addition, the assigned staff member will refrain from physically engaging with the distressed student.

Within a reasonable amount of time, if the distressed student does not de-escalate independently, assistance and guidance from parents/guardians will be requested by phone.

Parents or guardians of the distressed student will attend a mandatory meeting with administration and further steps to address the students social, emotional and behavioral needs will be addressed. A plan of action will be developed in order to best support the student with the resources available within HRQCC and at home. Resources and technical assistance will be requested in order to best avoid suspension or expulsion.

If the parents/guardians do not follow the collaborated action plan within a reasonable amount of time, the student may be suspended or expelled from the program to ensure the safety of all children and staff members.

A distressed student is defined as a student who is harming themselves or others, unable to listen to adults, unable to de-escalate independently.

Administration will ensure policies of behavior management and appropriate implementation of discipline policies are carried out by conducting weekly observations using the close-circuit security camera system. Administration will observe classroom interactions and engagements between staff and students. An observation chart will be maintained for accountability. Each classroom will be observed for at least five minutes, once a week, for six months.

In the event staff members need to report a concern or event pertaining to classroom management or behavioral policies, a radio is provided to each classroom and the director/owners direct phone numbers are provided to all staff members. In addition, an anonymous method of reporting is available by placing concerns in the front lobby suggestion box.

In the event a parent needs to report a concern or event pertaining to classroom management or the implementation of behavioral policies, HRQCC's phone number, email, and website comment section dedicated to families of the center are provided. In addition, the main lobby's suggestion box provides an anonymous method of reporting for all parties.

Upon notification of inappropriate discipline, care, or mistreatment of children, administration will immediately act by observing the staff member(s) in question and prepare to speak with them directly. In addition, administration will gather evidence from closed circuit video, interview and question staff members and if necessary, interview students involved with parent/guardian consent. The staff member in question will be pulled from the classroom and the concerns will be addressed with administration. A plan of action will be developed; a write-up, additional trainings, suspension, or termination will occur.

Current employees will receive "refresher" trainings pertaining to behavior management and discipline policies on a quarterly basis at staff meetings or in writing. Signatures of receipt will be requested by administration.

New hires will receive a copy of the behavior management and discipline policies in the employee handbook. A signature is required to document receipt and acknowledgment of the policies. This documentation will be retained in each employee's staff file.

Staff Member's Full Name: _____

Staff Member's Signature: _____ Date: _____

Cc: Staff File

Discipline and Behavior Agreement Continued

Reflection Time or "Time Out"

"Time Out" is the removal of a child for a short period of time (3 to 5 minutes) from a situation in which the child is misbehaving and has not responded to the other discipline techniques. The "time out" space, usually a chair or comfy area in the classroom, is located away from classroom activity but within the teacher's sight. During "time out," the child has a chance to think about the misbehavior which led to his/her removal from the group. After a brief interval of no more than 5 minutes, the teacher discusses the incident and appropriate behavior with the child. When the child returns to the group, the incident is over, the child is treated with the same affection and respect shown to the other children.

Adapted from and originally prepared by Elizabeth Wilson, Student, Catawba Valley Technical College

Biting Policy

This is for the health and safety of each child. We want to provide a friendly learning environment for all our children.

- **If your child bites TWO times in ONE day, your child will be sent home for the rest of the day.**
- **If your child bites FOUR times in ONE week, they will be sent home for the rest of the week.**

HRQCC: Out of the Fenced Area Permission

I give permission for my child to participate in activities **outside the fenced area of our playgrounds**. This includes but is not limited to walking to and from the playground and playing on the covered porch in front of our center.

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Employee Medical Coverage Elections Form

Plan begins one month after employment start date.

Employee's Full Name: _____

Information pertaining to each plan is available in the front office and digitally per request.

Please mark the plan below you would like to elect or if you are waiving election of a healthcare plan provided by UnitedHealthcare at 50% deducted from employee plan. An application will be provided to those who elect coverage.

Plan CD-D2 (monthly)	
Employee Only	$247.32
Employee Spouse	$741.96
Employee Child(ren)	$667.76
Family	$1,286.05

Plan CD-DR (monthly)	
Employee Only	$367.62
Employee Spouse	$1,102.86
Employee Child(ren)	$992.57
Family	$1,911.61

☐ *I will not be participating in United Healthcare Insurance and am waiving my right to benefits for this plan year.

SunLife–Dental (monthly)	
Employee Only	$24.49
Employee & Spouse	$47.27
Employee & Child(ren)	$76.18
Employee & Family	$98.97

SunLife-Vision (monthly)	
Employee Only	$10.95
Employee & Spouse	$21.91
Employee & Child(ren)	$24.10
Employee & Family	$35.04

☐ *I will not be participating in SunLife Dental OR Vision Insurances and am waiving my right to benefits for this plan year.

Employee Signature: _____ **Date:** _____

Cc: Staff File

(DO NOT STAPLE)

Employee Enrollment Form
North Carolina

UnitedHealthcare®

Coverage Provided by "UnitedHealthcare and Affiliates":
☐ Medical coverage provided by UnitedHealthcare Insurance Company (Insurance)
☐ Medical coverage provided by UnitedHealthcare Insurance Company of the River Valley (Insurance)
☐ HMO Medical coverage provided by UnitedHealthcare of North Carolina, Inc. (HMO)
☐ Medical coverage provided by All Savers Insurance Company (Insurance)
Dental, Vision, Life insurance, Disability and AD&D coverage provided by UnitedHealthcare Insurance Company

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer | **Requested Effective Date of Coverage/Date of Change** / /

Group Name Sneads Ferry Quality Childcare & Preschool | Policy Number 06L3422

Date of Hire / /

Position/Title

Hours Worked per week

Salary $_____ Required only if Life, STD, or LTD Plan based on salary

Reason for Application
☐ New Group Plan ☐ New Hire
☐ Life Event/Date_____ ☐ Annual Open Enrollment
☐ Status Change_____
☐ Dependent Add/Delete
☐ Change Name/Address ☐ Late Enrollee
☐ Part time to Full time
☐ Waiving Coverage ☐ Termination
☐ Other _____

Employee Type
(Check all that apply)
☐ Active ☐ COBRA ☐ State Continuation
Start dt ____/____/____
End dt____/____/____
☐ Hourly ☐ Salary
☐ Union ☐ Non-Union ☐ Retired
☐ Other _____

A. Employee Information

If you are waiving all coverage, please complete sections A and B.

Last Name	First Name	MI	Social Security Number
			___–___–____

Address	Apt #	City	State	Zip Code	Home/Cell Phone

Date of Birth	Gender	Marital Status	Work Phone
/ /	☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed	
		Language Preference, if not English	

Email Address

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No
Physician First & Last Name _____
Address _____
ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3]
Dentist First & Last Name _____
ID# _____
Existing Patient? ☐ Yes ☐ No

B. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date | Employee Signature if waiving all coverage

Employee Name ______________________________

C. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Spouse /Domestic Partner				☐M ☐F	/ /

Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

Relationship[4]	Last Name	First Name	MI	Sex	Date of Birth
Dependent				☐M ☐F	/ /

Social Security Number ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Do you use tobacco?[1] ☐Yes ☐No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐Yes ☐No

Primary Care Physician[2] Existing Patient? ☐Yes ☐No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ ___ ___

Primary Care Dentist[3] Existing Patient? ☐Yes ☐No

Dentist First & Last Name ______________________________

ID# ______________________________

Permanently disabled and age 26 or older[5] ☐Yes ☐No

(1) This question does not apply to dependents under the age of 18. Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) Please see employer representative as some dental plans require a Primary Care Dentist (PCD) selection. (4) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (5) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Employee Name _____

D. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D
Employee	☐ _____	☐ _____	☐	☐ $_____	☐ $_____
Spouse/Domestic Partner	☐	☐	☐	☐ $_____	☐ $_____
Dependent	☐	☐	☐	☐ $_____	☐ $_____

Person	STD	LTD
Employee	☐	☐

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

E. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___ ___ ___ End date ___ ___ ___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

F. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___ ___ ___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.
** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

G. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed except in connection with a claim, the authorization shall be valid for the term of the coverage. As provided under North Carolina law, you have the right to ask for and to receive a copy of the authorization form.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Sun Life Financial

One Sun Life Executive Park, Wellesley Hills, MA 02481

Sun Life Financial®

Group Enrollment Form

☐ Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

Employer use (check one): ☐ New employee ☐ Change ☐ COBRA

1. General Information

Employer Name	**Account / Policy Number**	**Location**
Sneads Ferry Quality Childcare & Preschool II	940517	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last) ☐ Male ☐ Female			**Date of Birth**
Street Address	**City**	**State**	**Zip Code**
Occupation	**Eligibility Class** (if applicable)	**Social Security Number**	**Phone Number**

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Return from layoff Date: ☐ Rehire

Current Active Employment Type	**Earnings** $
_____ # of hours ☐ Full-Time ☐ Part-Time	☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: _____

3. Dependent Information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full legal name (First, M.I., Last)	Gender	Social Security number	Date of birth	Student Y / N
Spouse					
Children					

4. Benefit Elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available.

Elect	Refuse	Coverage
☐	☐	Dental: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family Were you covered under another dental plan within the last 31 days? ..... ☐ Yes ☐ No If "Yes," provide the termination date: _____ Reason for termination of coverage? _____
☐	☐	Vision: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

5. Signature and authorization information

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant benefit waiting period specified in the certificate of insurance.
- For Dental Insurance plans, I have the right to select any dental care provider of my choice.
- The dental plan includes a pre-determination provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
- Coverages include benefit waiting periods, limitations and exclusions that may affect my entitlement to benefits.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

X _____ _____

Employee Signature Today's Date

To the Employee: Make a copy of this form for your records before submitting it to your employer.
To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

Contact us

By mail
Sun Life Financial
One Sun Life Executive Park
Wellesley Hills, MA 02481

www.sunlife.com/us

Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET

Key contacts to help you

Sun Life

Personalized contact list for Sneads Ferry Quality Childcare & Preschool II, policy 941879.

Service		
	Sun Life Client Services Monday through Friday 8 a.m. to 8 p.m. ET 800-247-6875 E-mail: clientservices@sunlife.com	
Billing		
	General E-mail: clientservices@sunlife.com Member Updates: customeradvocacy@sunlife.com Online: www.sunlifeconnect.com Fax: 888-888-8178 (updates) Fax: 781-431-7472 (other billing docs)	
Eligibility		
	E-mail: customeradvocacy@sunlife.com Fax: 888-208-2323 Online: www.sunlifeconnect.com	
Claims		
	Dental 800-442-7742 Fax: 563-242-0184 Sun Life PO Box 2940 Clinton, IA 52733-2940	**Vision** 800-877-7195 www.vsp.com
Web resources		
www.sunlife.com/us	Our website where clients can learn about us and do business with us. Brokers, employers, plan members and dental providers can access secure features to manage and administer benefits, submit and track claims, and make updates to their account information.	

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