employer solutions staffing group. Leveraging Resources in a Changing Market

Benefit Plan Administrators, Inc.

☐ New Employee
☐ Rehire *Rehire Date*________________

For Status Change Please Check: *You MUST provide a supporting Document*
☐ Change of Status Birth/
☐ Adoption
☐ Marriage
☐ Divorce
☐ Spouse Loss of Coverage Plan
☐ Change
☐ Cancel Employee/Dependents

Date of Status Change:

Benefits Enrollment Form

Employee Information

Name (Last, First, MI)	Date of Birth	Social Security Number	
McEligot,Aaron,P	11/02/1982	123-66-2492	
Address	**City**	**State**	**Zip Code**
89 East Main street apt 2F	Norwich	NY	13815

Gender	Marital Status	Phone Number:	Date of Hire
☑ Male ☐ Female	☐ Married ☑ Single ☐ Divorced	607-244-2932	1/19/20016

Please Select Coverage Elected: Enhanced MEC Plan

Coverage Level :

Email Address: mceligotaaron@gmail.com

☑ **Single - $24.00/Week** ☐ **Employee+Spouse - $38.00/Week** ☐ **Employee+Child(ren) - $36.00/Week** ☐ **Family - $63.00/Week**

Dependent Information

Dependent

Last Name First Name M.I. / Social Security #	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Dependent

Last Name First Name M.I. / Social Security #	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Dependent

Last Name First Name M.I. / Social Security #	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature Aaron McEligot
Aaron McEligot (Jan 20, 2016)

Date Jan 20, 2016

EMPLOYEES DECLINING ☐ **Declining due to other coverage.**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature

Date Jan 20, 2016

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

VSI 219301-EMP	OFFICE USE ONLY LOCATION_____	Rehire Date __/__/____

ENROLLMENT FORM - PLAN 2

ESC UNAV P2 v15.1

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK
(Must Be Filled Out)

Social Security Number 123-66-2492

Date of Birth 11/02/1982 Sex [M] [F]

Name Aaron McEligot

Street Address 89 East Main street APT 2F

City Norwich State NY Zip 13815

Home Phone 607-224-2932

Do you or any dependents have Medicare?

☐ Yes ☑ No If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date __/__/____

Names of Covered Person(s)

1.

2.

3.

REQUIRED DEPENDENT INFORMATION

Name

Social Security Number ___-___-____

Date of Birth __/__/____ Sex [M] [F]

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name

Social Security Number ___-___-____

Date of Birth __/__/____ Sex [M] [F]

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name

Social Security Number ___-___-____

Date of Birth __/__/____ Sex [M] [F]

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

BENEFIT SELECTION — Weekly Rates

SELECT COVERAGE LEVEL

You **MUST** select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.

☑ Employee Only ☐ Employee + Family

☐ Employee + 1 ☐ **NO to all indemnity benefits.**

FIXED INDEMNITY MEDICAL

☑ **YES** $20.91 Employee Only
$42.44 Employee + 1
☐ **NO** $56.67 Employee + Family

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

☑ **YES** $6.17 Employee Only
$12.34 Employee + 1
☐ **NO** $20.36 Employee + Family

TERM LIFE

☐ **YES** $0.60 Employee Only
$0.90 Employee + 1
☐ **NO** $1.80 Employee + Family

SHORT-TERM DISABILITY

☐ **YES**
☐ **NO** $4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

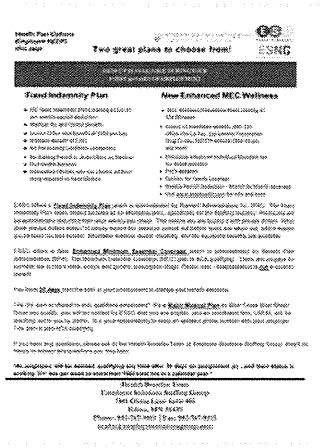
NAME OF BENEFICIARY

RELATIONSHIP

Accidental Death & Dismemberment is part of the Term Life Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

▶ **Signature** Aaron McEligot Aaron McEligot (Jan 20, 2016) Date Jan 20, 2016



Essential Staffcare Enrollment Form

Adobe Document Cloud Document History 1/20/16

Created:	1/20/16
By:	Caitlin Scholl (Caitlin@corpmgmtgroup.com)
Status:	SIGNED
Transaction ID:	CBJCHBCAABAA-VK043LP85HeqlDKqxFkSb8Xx--E434q

"Essential Staffcare Enrollment Form" History

Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)
1/20/16 - 2:37:31 MST - IP address: 96.93.208.70

Document emailed to Aaron McEligot (mceligotaaron@gmail.com) for signature
1/20/16 - 2:37:34 MST

Document viewed by Aaron McEligot (mceligotaaron@gmail.com)
1/20/16 - 3:10:12 MST - IP address: 66.249.83.243

Document e-signed by Aaron McEligot (mceligotaaron@gmail.com)
Signature Date: 1/20/16 - 3:42:07 MST - Time Source: server - IP address: 69.207.201.125

Signed document emailed to Aaron McEligot (mceligotaaron@gmail.com) and Caitlin Scholl (Caitlin@corpmgmtgroup.com)
1/20/16 - 3:42:07 MST