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	
Mota, Alexis	9/14/92	522-62-0561	
Address	**City**	**State**	**Zip Code**
105 Yakima St.	Lochbuie	CO	80603

Gender	Marital Status	Phone Number:	Date of Hire
☑ Male ☐ Female	☑ Married ☐ Single ☐ Divorced	720 357-6644	

Please Select Coverage Elected: Enhanced MEC Plan

Email Address: a_Mota14@Hotmail.com

Coverage Level :

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

Dependent Information

Dependent

Martinez Sherrer L	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I.	☐ Male ☑ Female	8/19/91	☑ Medical	☑ Add ☐ Change ☐ Waive ☐ Terminate
Social Security # 522-63-3185				

Dependent

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

Dependent

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

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 [signature] **Date** 3/14/16

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**

Employer Solutions Staffing Group Health Benefits Team
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Email: Health@employersolutionsgroup.com