

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information	
Name (First and Last) Alma D. Varela	Social Security Number 521.66.8334
Address 6791 E 76th PL	City Commerce City
State CO	Zip Code 80022
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Date of Birth 12/09/69	Date of Hire
Phone Number: 720.388.0844	Email Address: delalmar@gmail.com

Please Select Desired Coverage:
 Employee Only - \$24.00/Week
 Employee+Spouse - \$38.00/Week
 Employee+Child(ren) - \$36.00/Week
 Family - \$63.00/Week

Dependent				
First Name Jonathan	M.I. Varela	Last Name Varela	Social Security # 522-99-9719	Birth Date 03/02/76
			Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Dependent				
First Name Gabriela	M.I. Varela	Last Name Varela	Social Security # 650-38-9590	Birth Date 10/27/05
			Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Other coverage information including Medicare/Medicaid		
NAME OF PERSON COVERED (FIRST, LAST):		
Alma D. Varela	EFF. DATE	12/2015 2015
Jonathan Varela	EFF. DATE	12/2015 2015
Gabriela Varela	EFF. DATE	12/2015 2015

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 **Alma Varela** Date **06/24/2017**

EMPLOYEES DECLINING I am DECLINING 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 _____

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION

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

Name: Alma D. Varela Social Security #: 521-65-8334 Home Phone: 720-388-0844 Sex: M F

Address: 6791 E 76th PL Apt. #: _____

City: Commerce City State: CO Zip: 80022 Date of Birth: 12/09/69

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN): 0536086 Medicare Effective Date: 12/2015

Name of Covered Person (s):

- Alma D. Varela
- Gabriela Varela
- Jonathan Varela

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input type="checkbox"/>	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input checked="" type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			

¹ This coverage is not available to residents of NH, HI, or PR. ² STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name: <u>Gabriela Varela</u>	Social Security #: <u>050-38-9590</u>	Date of Birth: <u>10/07/05</u>	Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name: <u>Jonathan Varela</u>	Social Security #: <u>522-99-9719</u>	Date of Birth: <u>03/02/96</u>	Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name: _____	Social Security #: _____	Date of Birth: <u>/ /</u>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name: _____	Social Security #: _____	Date of Birth: <u>/ /</u>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

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.

DATE: 04/24/2017 SIGNATURE: Alma Varela