

Enhanced MEC Plan Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information

Name (First and Last) Annabelle Minyard		Social Security Number 610847548	
Address 7210 Winona Ct.		City Westminster	State Co
Zip Code 80030			
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 08/15/1995	Date of Hire 12/15/2016
Phone Number: 7202128339		Email Address: Ellebannamarie@yahoo.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	M.I.	Last Name	Social Security #	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
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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
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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
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Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):	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  Date Dec 20, 2016

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 Dec 20, 2016

Fixed Indemnity Medical Benefits_Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION _____ Rehire 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	Annabelle Minyard	Social Security #	Home Phone	Sex
		610847548	7202128339	<input type="checkbox"/> M <input checked="" type="checkbox"/> F
Address	7210 Winona Ct.			Apt. #
City	Westminster	State	Co	Zip
				80030
				Date of Birth
				08/15/1995

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) _____ Medicare Effective Date _____

Name of Covered Person (s):

1. _____ 2. _____ 3. _____

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 checked="" 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 type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80		
NO to ALL Benefits <input type="checkbox"/>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

¹This coverage is not available to residents of NH, HI, or PR. ²STD 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	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth	Sex	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<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 12/20/2016 / _____ SIGNATURE