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 469-49-4126

Date of Birth 10/30/1985 Sex [M] [F]

Name Bonita Sim

Street Address 13382 Hummingbird st nw

City Andover State MN Zip 55304

Home Phone 763-257-4650

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 Mason J Pflugshaupt

Social Security Number 785-59-3901

Date of Birth 07/28/2013 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 + 1
☐ Employee + Family
☐ NO to all indemnity benefits.

FIXED INDEMNITY MEDICAL

☒ YES
☐ NO

$20.91 Employee Only
$42.44 Employee + 1
$56.67 Employee + Family

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

DENTAL

☒ YES
☐ NO

$6.17 Employee Only
$12.34 Employee + 1
$20.36 Employee + Family

TERM LIFE

☒ YES
☐ NO

$0.60 Employee Only
$0.90 Employee + 1
$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
Mason J Pflugshaupt

RELATIONSHIP
Son

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** [signature] Date 01/04/2016

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employer solutions group.

Benefit Pla Admin ..ng, 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

Date of Birth 11 0 98

S S Number 46 - - 2

Ando

State

Zip Code 55304

ale (Female) Married (Single) Divorced

Phone Nu 763 - 7-

Date of Hire

Please Select Coverage Elected: nhanced MEC Plan

Email Address: Bonitasimio@yahoo.com

Coverage Level :

Single - $24.00/Week | Employee+Spouse - $38.00/Week | Employee+Child(ren) - $38.00/Week | Family - $63.00/Week

Dependent Information

D

Last Name First Name M

Social Security #

Birth Date

Male Female

Coverage Elected Medical

Add (Enroll) Change, or Terminate
Add Change
Waive Terminate

ame First Name M..

Social Security #

Sex

Female

Coverage Elected Medical

Add (Enroll) Change, or Terminate
Add Change
Waive Terminate

Dependent

Last Name First ame

Social Security #

Sex Birth Date

Male Female

Coverage Elected Medical

ro ge, or Terminate
Add Change
Waive Terminate

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

Date 12 22 15

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 out 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
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-8519 Fax: 952-767-8515
Email: Health@employersolutionsgroup.com