employer solutions staffing group
Leveraging Resources in a Changing Market

ESG employer solutions group

ESNG employer solutions nationwide group

bpa Benefit Plan Administrators, Inc.

Enhanced MEC Plan_Plan 1

Benefits Enrollment Form ☑ New Employee_ ☐ Rehire Rehire Date________________

Employee Information

Name (First and Last)				Social Security Number
Dane Menzel				354-82-3218
Address: 2801 E. 120th Ave Apt D104		City: Thornton	State: Co	Zip Code: 80233
Gender: ☑ Male ☐ Female	Marital Status: ☑ Single ☐ Married ☐ Divorced	Date of Birth: July 5th 1989		Date of Hire: 1/11/17
Phone Number: (217) 836-1407	Email Address: danedesigns89@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 M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Dependent

First Name M.I. Last Name	Social Security #	Birth Date	Sex	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

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 [signature] **Date** 1/20/17

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**

Employer Solutions Staffing Group Health Benefits Team
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