employer solutions staffing group
Leveraging Resources in a Changing Market

employer solutions group

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	
Zornick, Daniel R	02/21/1985	125-74-1578	
Address	**City**	**State**	**Zip Code**
380 St Lawrence Ave	Buffalo	NY	14216
Gender ☒ Male ☐ Female	**Marital Status** ☐ Married ☒ Single ☐ Divorced	**Phone Number:** 716-907-0275	**Date of Hire** 1/12/16

Please Select Coverage Elected: Enhanced MEC Plan

Email Address: dzornick24@gmail.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	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

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 Daniel Zornick Date 1/13/16

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
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

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 125-74-1578

Date of Birth 02/21/1985 Sex [M] F

Name Daniel Zornick

Street Address 380 St Lawrence Ave

City Buffalo State NY Zip 14216

Home Phone 716-907-0275

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 _____

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

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 + Family

☐ Employee + 1 ☐ NO to all indemnity benefits.

FIXED INDEMNITY MEDICAL

☒ YES $20.91 Employee Only
$42.44 Employee + 1
☐ NO $56.67 Employee + Family

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

DENTAL

☒ YES $6.17 Employee Only
$12.34 Employee + 1
☐ NO $20.36 Employee + Family

TERM LIFE

☒ YES $0.60 Employee Only
$0.90 Employee + 1
☐ NO $1.80 Employee + Family

SHORT-TERM DISABILITY

☐ YES $4.20 Employee Only
☒ NO

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

_____

RELATIONSHIP

_____

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 01/13/2016