

New Employee  
 Rehire Rehire Date \_\_\_\_\_

For Status Change Please Check: You **MUST** provide a supporting Document  
 Change of Status Birth/  Spouse Loss of Coverage Plan  
 Adoption  Change  
 Marriage  Cancel Employee/Dependents  
 Divorce  
 Date of Status Change:

Benefits Enrollment Form

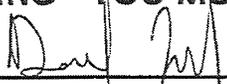
Employee Information			
Name (Last, First, MI) Zornick, David R		Date of Birth 02/21/1985	Social Security Number 125-74-1578
Address 380 St Lawrence Ave		City Buffalo	State NY
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Divorced	Phone Number: 716-907-0275	Date of Hire 1/12/16
Please Select Coverage Elected: Enhanced MEC Plan Coverage Level:		Email Address: dzornick24@gmail.com	
<input checked="" type="checkbox"/> Single - \$24.00/Week		<input type="checkbox"/> Employee+Spouse - \$38.00/Week	
<input type="checkbox"/> Employee+Child(ren) - \$36.00/Week		<input type="checkbox"/> Family - \$63.00/Week	

Dependent Information				
Dependent				
Last Name	First Name	M.I.	Sex	Birth Date
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #				Coverage Elected <input type="checkbox"/> Medical
				Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate
Last Name	First Name	M.I.	Sex	Birth Date
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #				Coverage Elected <input type="checkbox"/> Medical
				Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> Terminate
Last Name	First Name	M.I.	Sex	Birth Date
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #				Coverage Elected <input type="checkbox"/> Medical
				Add (Enroll) Change, or Terminate <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Waive <input type="checkbox"/> 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 premlums for coverages I have elected.

**IF ENROLLING - YOU MUST SIGN HERE**

Employee Signature  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 or 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 - 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  
 NO \$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  
 YES \$12.34 Employee + 1  
 NO \$20.36 Employee + Family

**TERM LIFE** 

YES \$0.60 Employee Only  
 YES \$0.90 Employee + 1  
 NO \$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**

\_\_\_\_\_

**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 Daniel Zornick

Date 01/13/2016