employer solutions staffing group
Leveraging Resources in a Changing Market

Benefit Plan Administrators, Inc.

☒ New Employee
☐ Rehire *Rehire Date*_____

Benefits Enrollment Form

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:

Employee Information

Name (Last, First, MI)	Date of Birth	Social Security Number
Clarke, David A	6-21-1962	011-54-1749

Address	City	State	Zip Code
764 S Chambers Rd #M102	Aurora	CO	80017

Gender	Marital Status	Phone Number:	Date of Hire
☒ Male ☐ Female	☒ Married ☐ Single ☐ Divorced	720 232 5996	7-2014

Please Select Coverage Elected: Enhanced MEC Plan

Coverage Level :

Email Address: dac1431@comcast.net

☐ 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
Clarke Cynthia T. (Last Name / First Name / M.I.)	☐ Male ☒ Female	3/19/61	☒ Medical	☒ Add ☐ Change ☐ Waive ☐ Terminate
Social Security #				
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name / First Name / M.I.	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate
Social Security #				
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name / First Name / M.I.	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate
Social Security #				

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):

DAVID A Clarke, DAVID A — EFF. DATE 1-1-16
Clarke, Cynthia T — EFF. DATE 1-1-16
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 David A Clarke Date 1-2-16

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
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Email: Health@employersolutionsgroup.com