

Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION _____

Rehire Date 01/15/2018

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name David Morales Social Security # 030-70-5595 Home Phone 773-968-5632 Sex M F
 Address 7216 W. Cullom Ave. Apt. # _____
 City Norridge State Illinois Zip 60706 Date of Birth 01/20/1989

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) _____

Medicare Effective Date _____

Name of Covered Person (s):

1. _____ 2. _____ 3. _____

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input checked="" type="checkbox"/>	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name _____ Social Security # _____ Date of Birth / / _____ Sex M F Relationship Spouse Child Domestic Partner
 Name _____ Social Security # _____ Date of Birth / / _____ Sex M F Relationship Spouse Child Domestic Partner
 Name _____ Social Security # _____ Date of Birth / / _____ Sex M F Relationship Spouse Child Domestic Partner
 Name _____ Social Security # _____ Date of Birth / / _____ Sex M F Relationship Spouse Child Domestic Partner

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

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.

DATE 02/04/2018

▶ SIGNATURE David Morales