

Enhanced MEC_Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date _____

Employee Information

| | | | | | |
|---|---|----------------------------------|--|---------------------------------|--|
| Name (First and Last) <i>Elmer Luis Fuentes Negrón</i> | | | Social Security Number <i>597-18-6061</i> | | |
| Address <i>Terrazas Demajaguas II calle esmeralda 35-186</i> | | City <i>Fajardo</i> | State <i>P.R.</i> | Zip Code <i>00738</i> | |
| Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced | Date of Birth <i>06-25-87</i> | | Date of Hire <i>03-19-18</i> | |
| Phone Number: <i>787-514-2868</i> | | | Email Address: <i>elmer.fuentes01@yahoo.com</i> | | |

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 <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|---|--|-------------------------|------------------|---|---|

Dependent

| | | | | | |
|---|--|-------------------------|------------------|---|---|
| First Name _____ M.I. _____ Last Name _____ | | Social Security # _____ | Birth Date _____ | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
|---|--|-------------------------|------------------|---|---|

Dependent

| | | | | | |
|---|--|-------------------------|------------------|---|---|
| First Name _____ M.I. _____ Last Name _____ | | Social Security # _____ | Birth Date _____ | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 *Elmer L. Fuentes* Date *04-17-18*

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 _____