

Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION _____ Rehire Date ____/____/____

ENROLLMENT FORM

FSC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION **PRINT USING BLACK or BLUE INK (Must Be Filled Out)**

Name: Jan Szumlakowski Social Security #: 331-86-3033 Home Phone: 773-931-3227 Sex: M F

Address: 6023 W. Melrose St. Apt. #: _____

City: Chicago State: IL Zip: 60634 Date of Birth: 01/11/1953

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 type="checkbox"/>	\$20.25 <input checked="" type="checkbox"/>	\$6.17 <input checked="" type="checkbox"/>	\$2.42 <input checked="" type="checkbox"/>	\$0.60 <input checked="" type="checkbox"/>	\$4.20 <input checked="" type="checkbox"/>
Employee + 1 <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

¹ This coverage is not available to residents of NH, HI, or PR. ² STD 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: Grazyna Szumlakowski Relationship: Wife

D. REQUIRED DEPENDENT INFORMATION

Name: <u>Grazyna Szumlakowski</u>	Social Security #: <u>356-68-3232</u>	Date of Birth: <u>11/16/1955</u>	Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name: _____	Social Security #: _____	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name: _____	Social Security #: _____	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name: _____	Social Security #: _____	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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: ____/____/____ SIGNATURE: Jan Szumlakowski