

ENROLLMENT FORM - PLAN 2

REQUIRED EMPLOYEE INFORMATION

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

Social Security Number 3 9 8 - 6 2 - 8 4 3 2

Date of Birth 0 7 / 0 1 / 1 9 5 5 Sex [M] [F]

Name Jeffrey R. Gamble

Street Address 8032 Ammons Way

City Arvada State CO Zip 80005

Home Phone 720 - 469 - 6147

Do you or any dependents have Medicare?

[X] Yes [] No If Yes:

Medicare Health Insurance Claim Number (HICN) 2975950-01

Medicare Effective Date Jan 2016 /

Names of Covered Person(s)

- 1. Regina Gamble
2.
3.

REQUIRED DEPENDENT INFORMATION

Name Regina Gamble

Social Security Number 521-88-8482

Date of Birth 07-20-1957 / Sex [M] [X] [F]

Relationship: [X] 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.

- [X] Employee Only [] Employee + Family
[] Employee + 1 [] NO to all indemnity benefits.

FIXED INDEMNITY MEDICAL

- [X] YES \$20.91 Employee Only \$42.44 Employee + 1
[] NO \$56.67 Employee + Family

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

- [X] YES \$6.17 Employee Only \$12.34 Employee + 1
[] NO \$20.36 Employee + Family

TERM LIFE

- [X] YES \$0.60 Employee Only \$0.90 Employee + 1
[] NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

- [X] YES \$4.20 Employee Only
[] NO

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

Date Mar 3, 2016 /

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) Gamble, Jeffrey R		Date of Birth 07/01/1955	Social Security Number 398-62-8432	
Address 8032 Ammons Way		City Arvada	State CO	Zip Code 80005
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Phone Number: 720-469-6147		Date of Hire 2-4-16

Please Select Coverage Elected: Enhanced MEC Plan
Coverage Level :

Single - \$24.00/Week
 Employee+Spouse - \$38.00/Week
 Employee+Child(ren) - \$36.00/Week
 Family - \$63.00/Week

Email Address:
jeff.biz.gamble@gmail.com

Dependent Information

Dependent

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

Dependent

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

Dependent

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

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 premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature: Jeffrey R. Gamble Date: Mar 3, 2016

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.

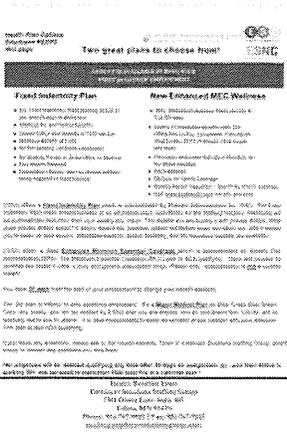
IF DECLINING- YOU MUST SIGN HERE

Employee Signature _____ Date: Mar 3, 2016

Essential Staffcare Enrollment Form

Adobe Document Cloud Document History

3/3/16



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“Essential Staffcare Enrollment Form” History

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